

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

30 January 2025

09:00am – 13:30pm

Ballroom, Bootle Town Hall,

Oriel Road

Bootle

L20 7AE



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



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Leading **integration** through **collaboration**

Public Speaking Time: 09:00am

Further detail at: <https://www.cheshireandmerseyside.nhs.uk/get-involved/upcoming-meetings-and-events/nhs-cheshire-and-merseyside-integrated-care-board-january-2025/>

Agenda

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
09:30am	Preliminary Business				
ICB/01/25/01	Welcome, Apologies and confirmation of quoracy	Verbal	Raj Jain ICB Chair	For information	-
ICB/01/25/02	Declarations of Interest <i>(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published on the ICB website)</i>	Verbal		For assurance	-
ICB/01/25/03	Chairs announcements	Verbal		For information	-
ICB/01/25/04	Experience and achievement story – South Sefton Primary Care Network	Presentation & Film	Dr Craig Gillespie <i>Clinical Director</i> Rachel Stead <i>Strategic PCN Manager</i>	For Information	Page 6
09:55am	Leadership Reports				
ICB/01/25/05	Report of the ICB Chief Executive	Paper	Graham Urwin <i>Chief Executive</i>	For approval	Page 22
ICB/01/25/06 10:05am	Report of the ICB Director of Nursing and Care	Paper	Chris Douglas <i>Director of Nursing & Care</i>	For assurance	Page 91
ICB/01/25/07 10:15am	NHS Cheshire and Merseyside Finance Report Month 8	Paper	Mark Bakewell <i>Director of Finance</i>	For assurance	Page 103
ICB/01/25/08 10:25am	Highlight report of the Chair of the ICB Finance, Investment and Resources Committee	Paper	Erica Morriss <i>Non-Executive Member</i>	For assurance	Page 135
ICB/01/25/09 10:30am	NHS Cheshire and Merseyside Integrated Performance Report	Paper	Anthony Middleton <i>Director of Performance & Planning</i>	For assurance	Page 141
ICB/01/25/10 10:40am	Highlight report of the Chair of the ICB Quality and Performance Committee	Paper	Tony Foy <i>Non-Executive Member</i>	For approval	Page 181

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
ICB/01/25/11 10:45am	Consolidated report of the ICB Directors of Place	Paper	Deborah Butcher <i>Place Director (Sefton)</i> Anthony Leo <i>Place Director (Halton & Liverpool)</i>	For assurance	Page 194
10:55pm	ICB Committee AAA Reports - matters of escalation and assurance				
ICB/01/25/12	Highlight report of the Chair of the ICB Remuneration Committee	Paper	Tony Foy <i>Non-Executive Member</i>	For assurance	Page 231
ICB/01/25/13	Highlight report of the Chair of the ICB Audit Committee	Paper	Tony Foy <i>Non-Executive Member</i>	For assurance	Page 233
ICB/01/25/14	Highlight report of the Chair of the ICB System Primary Care Committee	Paper	Erica Morriss <i>Non-Executive Member</i>	For assurance	Page 236
ICB/01/25/15	Highlight report of the Chair of the ICB Women's Hospital Services in Liverpool Committee	Paper	Prof. Hilary Garratt <i>Non-Executive Member</i>	For approval	Page 239
ICB/01/25/16	Highlight report of the Chair of the ICB Strategy and Transformation Committee	Paper	Dr Ruth Hussey <i>Non-Executive Member</i>	For assurance	Page 251
ICB/01/25/17	Highlight report of the Chair of the Cheshire and Merseyside Health and Care Partnership (HCP)	Paper	Raj Jain <i>ICB Chair/ HCP Vice Chair</i>	For assurance	Page 256
11:05am	COMFORT BREAK				
11:20am	ICB Business Items and Strategic Updates				
ICB/01/25/18	Learning from the Southport Incident — Deferred item	Presentation	Deborah Butcher <i>Place Director (Sefton)</i>	For approval	<i>Presentation on day</i>
ICB/01/25/19 11:35am	NHS Cheshire and Merseyside Freedom To Speak Up Update	Paper	Temitayo Roberts <i>Freedom To Speak Up Guardian</i>	For endorsement	Page 259
ICB/01/25/20 11:45am	NHS Cheshire and Merseyside ICB Board Assurance Framework & Corporate Risk Register 2024-25 Quarter Three Update	Paper	Clare Watson, <i>Assistant Chief Executive</i>	For approval	Page 300
ICB/01/25/21 11:55am	NHS Cheshire and Merseyside ICB Corporate Risk Register 2024-25 Quarter Three Update	Paper	Clare Watson, <i>Assistant Chief Executive</i>	For approval	Page 343

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
ICB/01/25/22 12:05pm	Reforming Elective Care for Patients in Cheshire and Merseyside	Paper	Anthony Middleton <i>Director of Performance and Planning</i>	For assurance	Page 408
ICB/01/25/23 12:25pm	Cheshire and Merseyside Cyber Security Update	Paper & Presentation	John Llewellyn <i>Chief Digital and Information Officer</i>	For approval	Page 418
ICB/01/25/24 12:45pm	Cheshire and Merseyside Data Into Action Programme Update	Paper & Presentation	Prof. Rowan Pritchard - Jones <i>Medical Director</i>	For assurance	Page 434
ICB/01/25/25 13:05pm	Update on Cheshire and Merseyside Neurodiversity Recovery Programme'	Presentation	Laura Marsh <i>Place Director (Cheshire West)</i>	For assurance	<i>Presentation on day</i>
13:20pm	Meeting Governance				
ICB/01/25/26	Minutes of the previous meeting: • 28 November 2024	Paper	Raj Jain <i>ICB Chair</i>	For approval	Page 441
ICB/01/25/27	Board Action Log	Paper	Raj Jain <i>ICB Chair</i>	To consider	Page 456
13:25pm	Reflection and Review				
ICB/01/25/28	Closing remarks and review of the meeting	Verbal	Raj Jain <i>ICB Chair</i>	For information	-
13:30pm	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/01/25/29	Board Decision Log - CLICK HERE TO VIEW	For information	-

Consent items

ICB/01/25/30	Confirmed Minutes of ICB Committees: <ul style="list-style-type: none">• <i>Audit Committee – September 2024</i>• <i>Children and Young Peoples Committee – August 2024</i>• <i>Finance, Investment and Our Resources Committee – 2024</i>• <i>Quality and Performance Committee – November 2024</i>• <i>Strategy and Transformation Committee – November 2024</i>• <i>System Primary Care Committee – October 2024</i>• <i>Women’s Hospital Services In Liverpool Committee – September 2024</i>• <i>Cheshire and Merseyside Health and Care Partnership – October 2024</i>	For assurance	Page 458
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Date and start time of future meetings

27 March 2025, 09:00am, Warrington Town Hall, Sankey St, Warrington WA1 1UH
29 May 2025, 09:00am, St Helens Town Hall, Victoria Square, St Helens, WA10 1HP
31 July 2025, 09:00am, Carlton Room, Hulme Hall, Port Sunlight, Wirral, CH62 5DH
25 September 2025, 09.00am, Holiday Inn, Lime Street, Liverpool, L1 1NQ
27 November 2025, 09:00am venue tbc

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

Following its meeting held in Public, the Board will hold a meeting in Private from **14:00pm**



SOUTH SEFTON
PRIMARY CARE NETWORK

Primary Care Network of the Year

South Sefton Primary Care Network

January 2025

Dr Craig Gillespie, Clinical Director and Rachel Stead, Strategic PCN
Manager

South Sefton wins PCN of the Year



South Sefton Primary Care Network has won at the prestigious General Practice Awards 2024. This award recognises SSPCN's outstanding contribution to collaborative general practice, improving health outcomes and partnership working to deliver integrated, patient-centred care for its patients.

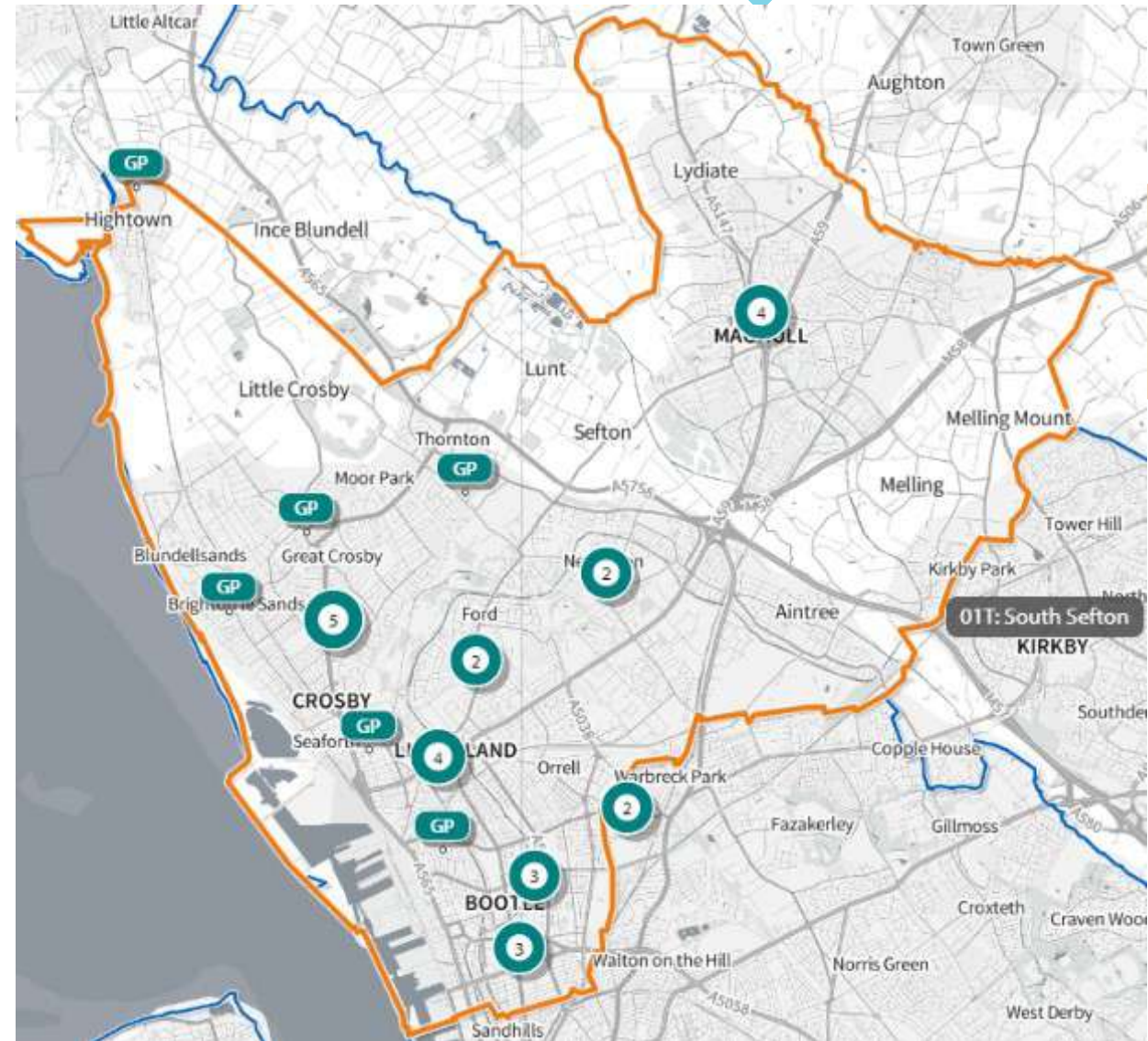
Our vision

A silhouette of a person stands on a beach, looking out at a sea under a dramatic sunset sky. In the distance, a line of wind turbines is visible on the horizon. The sun is low, creating a golden glow and casting long shadows on the water.


To improve health and wellbeing for people living in South Sefton and enable a sustainable, resilient health and care system

Introduction

- South Sefton PCN formed on 1 April 2022 bringing together Bootle, Crosby and Maghull PCN with Seaforth & Litherland.
- Made up of the 19 GP Practices of South Sefton, who care for 161,000 patients (some via subcontract).
- PCN operates a neighbourhood structure, each with clinical leadership to align with integrated care teams.
- Neighbourhood priorities established via close collaboration with practices and partners, and data in to action
- Around 100 PCN staff - either directly employed, hosted or seconded.

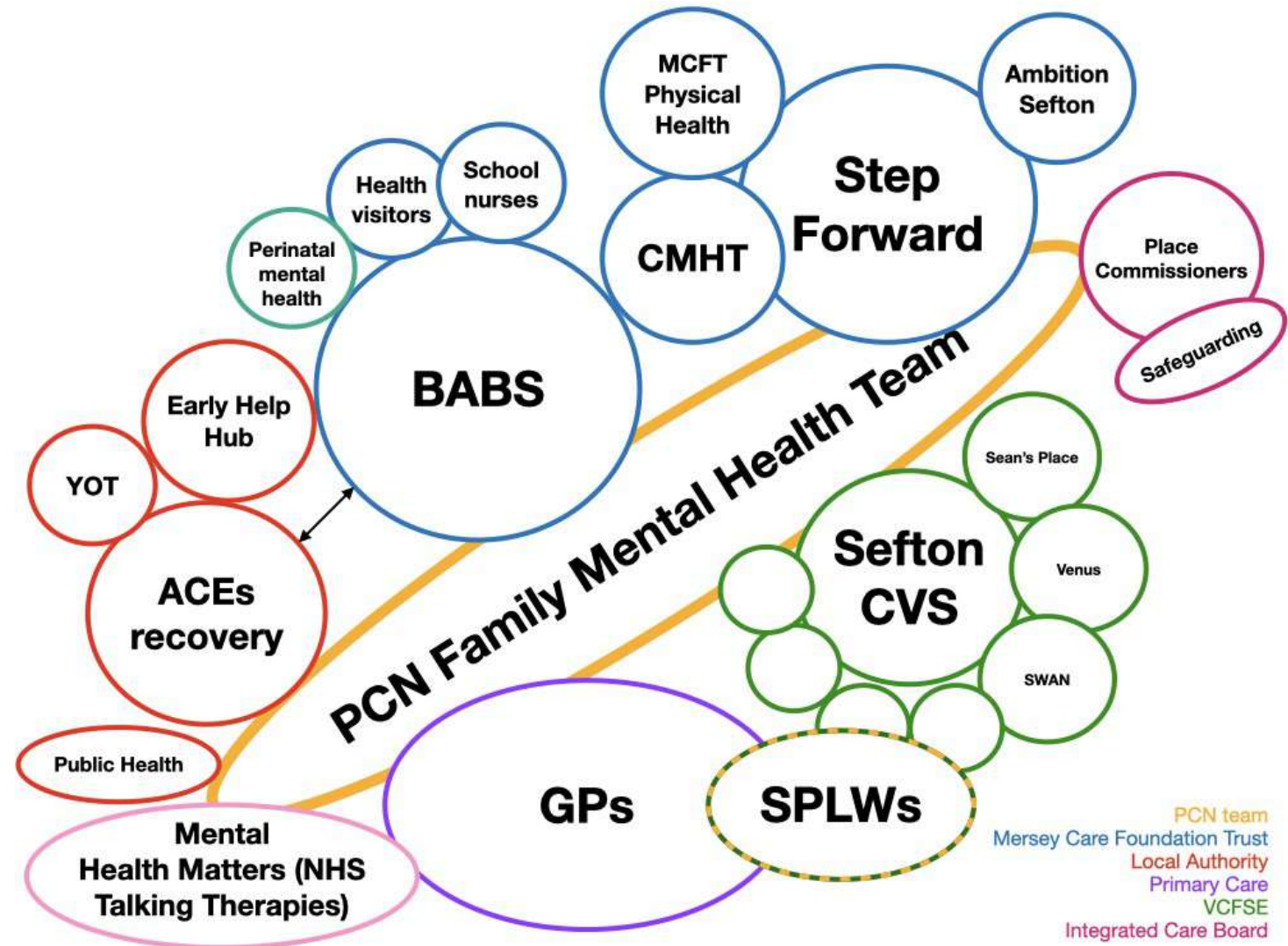


South Sefton PCN Strategy on a page

Context	PCN Vision and Objectives			Impact	
<ul style="list-style-type: none"> NHS Long term Plan GP Forward View Network DES Sefton Partnership ICS & Place Strategy HWBB Strategy Programme Delivery Group Fuller Stocktake Health Select Committee - Future of General Practice Sefton PCN Collaborative 	<p>South Sefton Primary Care Network aims to be at the heart of the integrated health and social care system for primary and community care</p> 			Improved access for patients via a wider range of services	
Key risks	<p>Strategic priority 1: Integrate Primary Care</p>	<p>Strategic priority 2: Expand the primary care workforce</p>	<p>Strategic priority 3: Work at scale</p>	Continuity of care for patients via integration – they tell their story once and have a joined up team approach	
<ul style="list-style-type: none"> Clinical systems interoperability Workforce Estates General Practice access PCN ‘scope creep’ and continuity of the contract Commitment to integration across organisations ICB changes: placed based support is vital 	<ul style="list-style-type: none"> Enhanced Health in Care Homes Enhanced Health at Home Primary Care mental health hub Tackling health inequality Integrated Care Teams 	<ul style="list-style-type: none"> Maximising benefit of Additional Roles Reimbursement Scheme Unified Learning Environment 	<ul style="list-style-type: none"> Medicines Management Hub Acute home visiting service Admin Hub Proactive Care team Estates plan 	Quality of care increases.	
Strategic Enablers					
<p>Governance arrangements PCN Structure Workforce Plan Communications and engagement (via place) Systems and digital innovation</p>		<p>Financial management Risk management Business Intelligence (via place) Estates Quality and performance</p>			<p>Services are levelled up, reducing health inequality</p> <p>Primary care staff are retained through better training, portfolio careers and increased MDT support</p> <p>Primary care becomes sustainable</p> <p>More effective population health management</p>

Partnerships

- Why we think we won
- Relationships across Sefton place
- Critical to delivery of an effective PCN
- Collaborate to sustain
- High trust enables innovation



The background features several large, overlapping geometric shapes in teal, orange, and grey, primarily located in the corners and along the right edge. The text is centered in a dark blue, bold font.

Adverse Childhood Experience Group Programme - Participant Video

South Sefton Access Service

- Acute Respiratory Infection Hub launched 14 February 2023
- Increased scope to include wider range of acute minor illnesses for patients aged 2+.
- Treated just over 35,000 patients
- Working with Local Pharmacy Committee to maximise benefit of Pharmacy First.



Integrating Care - Enhanced Health at Home

Enhanced Health at Home supports the aims of the Sefton strategy by establishing a team focused on integration of services with the Sefton partnership to enable older patients who want to live at home to remain to do so, maintaining high quality of life, and appropriate support to retain independence.

1. Patients have a regular named team that operate a 'no wrong door' policy
2. Patients are contacted proactively and regularly by Care Co-ordinators and Social Prescribing Link Workers
3. Patients remain well, and avoid in-patient admissions or re-admission through proactive medication reviews, acute visiting service, etc.



Learning disability health checks

- Expanded PCN team to support practices in visiting patients at home who have not attended surgery for their annual learning disability health check.
- Having time to visit patients at home, or at day centres is improving uptake of health checks.
- Recently, a nurse associate, Sarah after several attempts, made contact with a patient who not been seen for some time and discovered them living in extremely poor home conditions. The patient had not eaten a meal for days, and they were acutely unwell. Sarah went out to buy the patient a meal. She was able to liaise with the practice safeguarding lead to arrange urgent referral and made arrangements with a several other agencies to ensure appropriate intervention.

Working at scale - Medicines Hub

- Discharge hub
- Care Plans for Care home residents (320 completed Q1 and Q2)
- Impact and Investment Fund
- Structured Medication Reviews
- Outreach clinics via VCF organisations
- Specialist clinics in development (eg Women's health hubs)
- ICT MDTs including Virtual Wards, Enhanced Health at Home and Enhanced Health in Care Homes
- Quality Improvement in General Practice

Impact on safety

In the first half of 22/23

- Responded to 9,500 medicines queries, including 400 calls to secondary care and 1700 calls to patients
- 6600 post hospital discharge summaries
- 822 Structured Medication reviews for patients at risk of harm from their combinations of medication
- 2267 medication reviews for patients at risk of gastric bleed
- 924 reviews of controlled drug prescribing
- 1006 medication reviews for new patients in Sefton

Impact on cost

Medicines hub is forecast to deliver £1.2m prescribing cost savings in 2022/23 for Sefton

Impact on workload

For GPs: *"The support from the hub has been magnificent and they are all so professional their expertise is valued by all GPs. We cannot stress the amount of time it has saved our clinicians"*

For secondary care: 1.8 WTE Pharmacists supporting intermediate care and virtual ward teams

Impact on patients

A patient was admitted to hospital for a very short stay with no time for a hospital pharmacist to review discharge medication. The medicines hub noted that doses of two medications appeared to have been reduced inappropriately. A hub pharmacist queried this with the ward doctor who confirmed the discharge information was incorrect. If the hub pharmacist had not identified this, it is probable the patient would have required re-admission.

Impact – Working with Voluntary & Community Partners

MYA - Space Open Space Project/Art Therapy Priority Area: Anxiety and Depression

The project has been very successful for the young people who have been involved. With improvements being made in different areas such as confidence, self-esteem, relationships, knowledge understanding, supporting one another and overall having positively achieved what they have sent out to do. Throughout the process, young people have learnt new skills and gained new interests making them have a more positive outlook for life in the future. They have addressed issues and came up with solutions along the way, creating a self-support and help strategies. In the shape of a magazine for young people about young people putting issues in the "SPOTLIGHT".

"This project has really helped me express how I feel, and I know I have people who I can share my thoughts with and they can help me."



"I would definitely, recommend this project to other people ...I know that other people my age are struggling with problems and how I can help them."

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young people have gained support with their mental health and wellbeing relieving pressure in primary/community care whilst engaged within this project.

After young people completing our MYA outcome star looking at: Motivation, Resilience, Skills, Aspirations, Belonging, improvements were made in all areas such as:



PCN Winter Access Community Grants

'Thank you for all your help'

Chris was diagnosed with lung cancer in May 2022. He lives in a 3rd floor flat, with his wife who has mobility issues.

A Cancer navigator completed a holistic needs assessment (HNA) and Chris' main concerns were his difficult getting out of his flat, needing help accessing the over-bath shower and feeling low in mood.

As a result the Navigator referred Chris for counselling, requested a benefits check, helped Chris apply for a blue badge, made a referral to OT and followed up pulmonary rehab.

As a result Chris received a blue badge, which has enabled him to get out more easily, and has been receiving talking therapy from Sunflowers Cancer support group

PCN funded Cancer Navigators

Future Plans

- Completed 'EvoGP' consultation – consulting member practices and system partners about how general practice in south Sefton should evolve
- Vision for further collaboration is wide and deep
- Recommendations will become the strategic plan for the next PCN period

PCN Strategic planning / connectivity with health & care system

Core General Practice

Retains list-based practice and autonomy
Partnership model and multi-practice providers co-exist
Underpinned by PCN services

Complex Patients – continuity essential, seen by own GP

Unwell patients – would benefit from continuity where possible

Generally well patients – would benefit from quick access

Amber patients may be seen in if access more important than continuity

Prioritised to seen in Acute & Minor illness Hub / EAS

Existing PCN services (Pharmacist Hub, EHCH / EHAH / Mental Health team / LD / SSAS)

Central services responding to key risks eg nurse workforce, health inequality

New specialist primary care PCN services to be agreed

Enabled through SSPCN Ltd

Future Plans

- Existing services are business as usual, developing a strong track record of effective delivery
- Ready for investment and opportunities for further system collaboration.



Thank you

Meeting of the Board of NHS Cheshire and Merseyside

30 January 2025

Report of the Chief Executive

Agenda Item No: ICB/01/25/05

Responsible Director: Graham Urwin, Chief Executive



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Report of the Chief Executive (January 2025)

1. Introduction

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

2. Ask of the Board and Recommendations

- 2.1 **The Board is asked to:**
- **consider** the updates to Board and seek any further clarification or details
 - disseminate and cascade key messages and information as appropriate
 - **approve** the variation to the Specialised Commissioning Delegation Agreement set out in Appendix One

3. New Starter and Interim arrangements

- 3.1 I would like to extend a warm welcome to Mike Gibney, our new Chief People Officer, who is attending his first meeting of the ICB Board today. Mike has joined us from The Walton Centre NHS Foundation Trust and brings with him extensive experience of human resources, organisational development, education, and innovation.
- 3.2 Board members were also aware that with Mark Bakewell taking on ICBs Executive Director of Finance role for an interim period that there was a vacancy for the ICBs Liverpool Place Director role. I am pleased to announce that, whilst work continues in progressing the work around the future operational model of the ICB, that Anthony Leo, Place Director for Halton, has also agreed to undertake the Liverpool Place Director role.
- 3.3 Additionally, Mark Wilkinson, ICB Place Director for Cheshire East will be leaving this post at the end of March 2025, and as such the ICB is currently out for internal advert to identify an interim arrangement to cover this post. The Board will be kept informed of progress.

4. Specialised Commissioning Arrangements

- 4.1 Following the delegation of 59 specialised services to the ICB in April 2024, NHS England has approved the delegation of an additional 25 services to the ICB as of 01 April 2025. Appendix One to this report describes in more detail these services and key aspects of our working arrangements in the North West.



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Appendix Two includes a revision to the current Delegation Agreement with NHS England.

- 4.2 The transfer of services and delegation agreement have been considered in the Cheshire and Merseyside Specialised Commissioning Oversight Group in January 2025 and a “deep dive” into the progress to date and plans for further delegation in 2025-26 took place at the January 2025 ICB Strategy and Transformation Committee.
- 4.3 As part of this work the three North West ICBs have collaborated on the development of a Target Operating Model, to support the NHS England North West Specialised Commissioning Team and the three ICBs to work collaboratively to commission specialised services on the appropriate footprint for both delegated and retained services. This is currently in development and is expected to be completed by June 2025.
- 4.4 Planning is underway to prepare for the transfer of the staff from the North West Specialised Commissioning Team to NHS Lancashire and South Cumbria ICB as a host employing organisation of a single shared service. Arrangements will be reviewed regularly to ensure they are effective and fit for purpose and an update will be provided to the Board in Quarter One of 2025.
- 4.5 The ICB will receive direct allocations to commission specialised services for our population. The North West Specialised Commissioning Hub will provide a financial management service for this allocation. The Hub works with the ICBs to develop and agree a financial plan through the finance sub-group. All financial decisions will be agreed in line with each ICBs financial governance for single ICB services. For those multi-IBC services financial decisions will be agreed via the joint commissioning committee. The hub will monitor and report delivery of this plan into the ICBs.
- 4.6 From April 2025, contracting for delegated services along with retained specialised services and other NHS England non-specialised services (Health and Justice, Armed Forces and Section 7a) will be included within the ICB contract. Work has commenced with the regional contract leads to set out an operating model to support these arrangements with the hub continuing to undertake contract negotiation and management of the specialised elements of the contract whilst minimising duplication where appropriate. As part of the North West work programme a review of the existing Mental Health Provider Collaborative arrangements is also planned during 2025-26 with ICBs and Providers.

The Board is asked to:

- **approve** the variation to the Specialised Commissioning Delegation Agreement set out in **Appendix Two**
- **note** the update on the creation of the North West Specialised Commissioning Hub Shared service within the North West region and hosted by NHS Lancashire and South Cumbria ICB on behalf of the North West ICBs.



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- **note** the proposed payment arrangements set out in Summary document in **Appendix One**.

5. Funding to Hospices

- 5.1 On the 19 December 2024 the Government announced a £100million funding boost for adult and children’s hospices and £26 million to support children and young people’s hospices.¹ This investment will go towards helping hospices to improve their buildings, equipment, and accommodation to ensure that patients continue to receive the best care possible, as well as help to develop and bettering outreach services to support people in their own homes when needed. Further details regarding the funding is due to be shared with the hospice sector. As at the time of writing this report I have not seen any further detail with regards the level of investment that will come to hospices in Cheshire and Merseyside.

6. Thirlwall Inquiry

- 6.1 Substantive hearings of the [Thirlwall Inquiry](#) – established to examine events at the Countess of Chester Hospital and their implications following the trials and subsequent convictions of former neonatal nurse Lucy Letby – concluded on 17 January 2025 ahead of closing arguments scheduled for 17 March 2025.
- 6.2 A report containing key learning and recommendations will then be collated and published at a later date. In line with the terms of reference of the inquiry, the report is expected to address:
- the experiences of the impacted families
 - the conduct of those working at the Countess of Chester Hospital, including the board, managers, doctors, nurses and midwives with regard to the actions of Lucy Letby
 - the effectiveness of NHS management and governance structures and processes, external scrutiny and professional regulation in keeping babies in hospital safe and well looked after.

7. Southport

- 7.1 In July 2024, we were all deeply shocked by the tragedy in Southport which claimed the lives of three young girls – Bebe King, Alice da Silva Aguiar and Elsie Dot Stancombe. On the first day of a scheduled four-week trial (Monday, 20 January 2025) Axel Rudakubana changed his pleas to guilty on all charges – including three counts of murder and 10 counts of attempted murder. He was sentenced at Liverpool Crown Court on Thursday, 23 January 2025. Additionally, the Home Secretary Yvette Cooper has announced that the

¹ <https://www.gov.uk/government/news/biggest-investment-into-hospices-in-a-generation>

Government will establish an independent public inquiry.² At the time of writing this report no further details have been released on this.

- 7.2 We have continued to communicate with our staff who may have been affected by this tragic event regarding the range of support that is available to them and their families. The dedicated [Southport Together](#)^[1] section of the Sefton Council website contains information about a range of support services, while information about a number of additional support options are available via the ICB's Staff Hub.
- 7.3 At this meeting in January 2025, the Board will hear further from Deborah Butcher, ICB Place Director for Sefton and also Executive Director of Adult Social Care for Sefton Council who had an instrumental role in responding to events on the day and subsequent public disorder incidences, as well as leading the long term response in the Southport Community.

8. Devolution White Paper

- 8.1 On 16 December 2024, the government released the English Devolution White Paper,³ setting out plans to accelerate and standardise the transfer of powers, funding, and responsibilities from Westminster to local areas, which will include the Liverpool City Region Combined Authority and also a new agreement covering the three local authority areas in Cheshire and Warrington, Cheshire East, Cheshire West and Chester and Warrington councils, working alongside Enterprise Cheshire and Warrington.
- 8.2 Central to this plan is the introduction of “strategic authorities” to build on previous devolution agreements. The White Paper will give Mayors power over:
- Planning and housing, putting our regions at the centre of the drive to build 1.5 million homes in this Parliament;
 - Transport, to drive a locally integrated transport network that truly works for their communities and supports local economic growth, with improved train services and better travel to and from rail stations, by bus, tram, and active travel;
 - Skills and employment support to so everyone has the opportunities they deserve and can access good jobs;
 - Local Growth Plans to accelerate regional growth and productivity, setting a long-term vision for the next decade, and a roadmap for how this will be achieved – driving the government’s central mission of economic growth and putting more money in people’s pockets.
- 8.3 The white paper also outlines the role of strategic authorities in “joining up public services” and taking a holistic approach to addressing social determinants of health. They will align with Integrated Care Systems (ICS) more

² <https://www.gov.uk/government/speeches/southport-attack-next-steps>

^[1] <https://www.sefton.gov.uk/southport-together/>

³ <https://www.gov.uk/government/publications/english-devolution-white-paper-power-and-partnership-foundations-for-growth/english-devolution-white-paper>



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closely with local leadership, and strengthen the role of communities in shaping public services. The new framework highlights expectation for strategic authorities' growing role in shaping several areas, including health, wellbeing, and public service reform. Key highlights include:

- more freedom given to Mayors over their funding and priorities and expectation that they will play key roles in ICSs, from Integrated Care Partnerships (ICPs) to informing Integrated Care Board (ICB) priorities and in appointing ICB Chairs.
- devolution across the whole of England through the creation in law of the concept of a 'strategic authority,' covering areas with populations of generally 1.5 million people or above. There will be three levels of strategic authority, holding varying degrees of power depending on their maturity and whether they have a mayor.
- the paper introduces a new bespoke duty in relation to health improvement and health inequalities, complementing the existing health improvement duty held by upper-tier local authorities.
- a devolution priority programme will fast-track this process and will see more new mayors elected from May 2026.
- there is a clear longer-term ambition and expectation that public service boundaries will be aligned, which will have implications for ICS geographies. Any changes to public service boundaries will be made in consultation with stakeholders and considering the impact on service delivery.
- at the more local level, the government expects all two-tier areas and smaller or failing unitary authorities to develop proposals for reorganisation. This will likely, for most areas, see larger unitary authorities created serving areas with a minimum population of 0.5 million.

8.4 A useful summary of the white paper can be found on the [NHS Confederation website](#).⁴

8.5 The ICB has engaged with and is working closely with our Local Authority Partners in Cheshire and Merseyside to determine how best we contribute to the work underway locally around devolution, including considering the possibilities for the Cheshire and Merseyside Health and Care Partnership as well as the future operating model of the ICB. The Board will continue to be updated on progress around local devolution and will be involved in determining how the ICB plays a part in this.

9. Independent Commission on building a National Care Service

9.1 Colleagues will hopefully have noted the announcement by Government on 03 January 2025 regarding the launch of an independent commission for adult social care to 'build consensus' for the proposed National Care Service. The independent commission, chaired by Baroness Louise Casey, will invite people drawing on care and those involved within the care system to "make clear recommendations for how to rebuild the adult social care system to meet the current and future needs of the population."

⁴ <https://www.nhsconfed.org/publications/english-devolution-white-paper>

- 9.2 The first phase of the commission will identify the "critical issues" and recommend "tangible, pragmatic solutions that can be implemented in a phased way to lay the foundations for a National Care Service" will be submitted to the prime minister the middle of 2026. While the next phase, set to be finalised by 2028, will "make longer-term recommendations for the transformation of adult social care" and shape how services should be organised to best "create a fair and affordable adult social care system for all".
- 9.3 We will work with local partners to support this commission where we can and will provide the Board with further updates when able to do so.
- 9.4 Additionally, on the 10 January 2025, Local Authorities received correspondence from Government regarding [Adult Social Care - Local Authority Expenditure and Budget-Setting](#)⁵ and which outlined details on current and expected fee rates for adult social care providers, highlighting that research had shown that there had been an increase in fee rate of an average of 12.1% across adult social care service types in 2023/24, and that that provisional fee rates for 2024/25 indicate an average uplift of 6.3%. The Annexes to this letter provide details on the average fee rates by local authority area.

10. Annual ICB Performance Assessments 2023-2024

- 10.1 NHS England have published a summary report⁶ of the assessment of each ICB covering how effectively they have led their local NHS system and their contribution to each of the four core purposes of an integrated care system. It summarises an assessment of performance during the 2023/24 financial year and reflects NHS England's views relating to that period only; it does not necessarily indicate NHS England's current views of performance. For Cheshire and Merseyside, the summary report highlighted the following:
- **System leadership** - the ICB is developing at pace, with a purposeful, cohesive executive structure and well-established, place-level structures. It leads effectively with its partners and facilitates system collaboration to tackle common problems. This is delivering positive shared outcomes such as the move toward a single Electronic Patient Record in Liverpool. Internal audit reports gave good assurance of the robustness of ICB governance and oversight.
 - **Improving population health and healthcare** - the ICB is seeing success, particularly in reducing inappropriate mental health out-of-area placements, performing strongly against cancer recovery measures and supporting Liverpool University Hospitals NHS Foundation Trust to exit the Recovery Support Programme. Urgent care remains a challenge, and we will continue to provide support through Tier 1 of the Urgent and Emergency Care (UEC) Recovery Programme. We will also be looking to see progress alongside local authorities to reduce patients without clinical reason to reside.

⁵ <https://westcheshireway.glasscubes.com/share/s/pi11o7e1ti3q0s29i3s9vkr6a0>

⁶ <https://www.england.nhs.uk/publication/annual-assessment-of-integrated-care-boards-2023-24/>

- **Tackling unequal access, outcomes and experience** - the ICB has effectively led the development of a strategic approach to population health management and reducing health inequalities and will set this out in its forthcoming health and care partnership plan. Early progress on this agenda is already being seen in the ICB's use of targeted lung health checks to support improvements in early-stage cancer diagnoses and exceeding the national target for establishing women's health hubs. We look to see continued progress on this plan next year, underpinned by accurate data.
- **Enhancing productivity and value for money** - despite the ICB reporting an organisational surplus, the system reported a significant deficit against the breakeven plan, driven by higher than planned spending on continuing healthcare and primary care. The ICB delivered its efficiency plan but marginally under-delivered against its system plan. Both plans fell short on planned levels of recurrent saving. We have agreed a control total with the ICB for the year ahead and to achieve this the ICB must focus on boosting productivity and achieving further recurring efficiencies across the system.
- **Supporting social and economic development** - the ICB is leveraging its role as a major anchor institution and was the first in the country to receive the Social Value Quality Mark[®] Health Award in recognition of its commitment to this role. It has been instrumental in the development of the system's social value charter and scaling up prevention priorities through the prevention pledge, promoting sustainability and tackling violence, discrimination and housing issues

10.2 Overall, I am pleased with the NHS England assessment and that they have recognised our examples of best practice work in areas such as cancer performance and social value, and I welcome the ongoing commitment/support from NHS England and wider system partners in supporting our activity to improve performance in areas such as urgent emergency care.

11. Launch of consultation on cessation of NHS funded Gluten Free Prescribing

11.1 Following Board approval at its meeting in November 2024 to progress to public consultation regarding the cessation of NHS funded gluten free (bread and bread mixes) prescribing, the ICB has been engaging with the relevant Local Authority Health Scrutiny Committees to seek their decision on whether they require the ICB to directly consult with them. So far there have been four Local Authority Scrutiny Committees who have considered our proposal to constitute a significant development or variation, therefore triggering the requirement for us to formally consult with them. The last Local Authority Scrutiny meeting to consider the proposal is on 11 February 2025 where at that point we will know which Local Authorities will need to form a Joint health Scrutiny Committee to consider the outcome of our consultation and proposals ahead of the final decision making paper coming back to Board at its May 2025 meeting.



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- 11.2 The ICBs 6-week consultation with the public will have started on the 28 January 2025 and will close on the 11 March 2025. All feedback received will be collated and analysed and will be used to support us to make the final decision. Details on the consultation can be found on our website at: <https://www.cheshireandmerseyside.nhs.uk/get-involved/current-consultations-and-engagements/>

12. Proposed changes to ICB Clinical Policies

- 12.1 NHS Cheshire and Merseyside is inviting views to help update 25 clinical policies for treatments and procedures in line with the latest evidence of what works best, in the third phase of its harmonisation programme to also ensure equal access for patients no matter which part of the area they live in.
- 12.2 A total of 25 policies inherited by NHS Cheshire and Merseyside from predecessor clinical commissioning groups (CCGs) are being reviewed during the lifetime of the programme. This is to remove any variation that exists between different CCG areas and to ensure they meet the most up to date medical evidence, guidance and best practice.
- 12.3 These policies cover some specific treatments and procedures, such as acne treatment in hospital and keyhole surgery for hip impingement, which often only benefit certain groups of patients in some particular medical circumstances. The policies set out when and often where these treatments and procedures should be used, and which patients would benefit medically from them.
- 12.4 In general, the proposed changes are minor, however, because they could mean that the way patients access care might be different. People are being encouraged to give their views in an online survey to help harmonise and finalise these documents.
- 12.5 You can find more detailed information about the programme, along with details of how to complete the survey before 19 February 2025 at: <https://www.cheshireandmerseyside.nhs.uk/get-involved/current-consultations-and-engagements/clinical-policies-share-your-views/>
- 12.6 Once the engagement period closes, responses will be collated and compiled into a report. These findings will be used to help us make a final decision about the policies.

13. Vaccination Updates

- 13.1 **Covid-19.** The National Booking service closed on the 20 December 2024, and a small number of sites (approximately 70) remain open for walk-ins whilst the vaccine is still available.

- 13.2 Uptake across the population is currently (as at 19 January 2025) Nationally 44.27%, Northwest 39.6%, Cheshire and Merseyside 42.3%, Greater Manchester 35.01%, and Lancashire and South Cumbria 42.41%
- 13.3 NHS Trusts received funding to support their frontline Healthcare Worker (HCW) Flu and Covid vaccination programme which was utilised on activity such as roving vaccine delivery, staff incentives, additional vaccination staff. ICB Communication colleagues have supported the rollout of the vaccination campaign to staff utilising Trust comms channels, bulletins, video content, screen savers. Despite these efforts, uptake of winter vaccinations in frontline HCWs across C&M has remained low.
- 13.4 NHS Trust uptake (as at 31 December 2024) in Cheshire and Merseyside is 20.3% (National 20.8%) for Covid and 36.9% for flu (National 40%). This is a decrease of approximately 10% from Autumn winter 2023 where uptake was 30% for covid and 46.42% for flu. In response to this staff vaccine behavioural insight will be carried out to explore the key barriers and enablers to vaccine uptake among frontline health and care staff and to provide strategic recommendations to help increase uptake ahead of next winter. At the November 2024 Board, it was requested that further uptake figures be provided to Board, which is provided in Appendix Three.
- 13.5 100% of Cheshire and Merseyside care homes have received at least one visit and 99% of homes are complete. The four homes yet to be completed are in Liverpool, these homes have been visited on numerous occasions but due to resident requirements (residents with learning disabilities) have not yet been completed. Providers will continue to visit to reach residents that still require vaccination until the end of campaign on the 31 January 2025.
- 13.6 **Living Well Bus.** The service continues to deliver covid, flu and routine vaccinations and health checks to hard-to-reach communities building on relationships built over the last four years. Post the close of the covid-19 vaccination campaign at the end of January the service will continue to deliver the wider health offer and phase 2 of the cervical screening pilot. The Living Well Bus Service has also undertaken co-located clinics with Liver screening and more are planned, for example is co located clinics with the University Hospitals Liverpool Group research bus, AAA screening and Diabetic Eye screening and well as a health promotion day in Cheshire East in collaboration with the cancer alliance and mental health charities.

14. Change NHS – 10 Year Health Plan for England.

- 14.1 When the Government lunched Change NHS, they said they wanted this to be the biggest ever conversation about the NHS, and since its launch in October 2024, more than 1 million people have visited the [Change NHS website](https://change.nhs.uk/en-GB/)⁷ – leading to over 60,000 responses to the online survey so far.

⁷ <https://change.nhs.uk/en-GB/>

- 14.2 Here in Cheshire and Merseyside we have been working hard with our partners to spread the word – to both staff and residents - and to encourage people to take part. The ICB has run a series of staff events to gather feedback on what matters to them, and working with our voluntary sector partners, has also arranged public engagement activity to gather the views, experiences and ideas of a range of audiences.
- 14.3 In doing so, we have heard both from people with multiple long term health conditions and some of our underserved communities – including ethnic minorities communities, people in contact with the justice system, people experiencing homelessness, and people experiencing drug and alcohol dependency. In a little over 2 weeks' time (by 14 February) organisations are required to submit the feedback and insights gathered to help shape the new 10 Year Health Plan.
- 14.4 Thank you to everyone who has got involved so far. If you're new to Change NHS, you can still take part in all the activities and have your say.⁸

15. Cancer Survival

- 15.1 For the first time ever, five-year cancer survival rates in Cheshire and Merseyside are now better than the England average. This is a very positive milestone for our population, especially as we have also seen great improvements in the proportion of patients diagnosed with early stage cancers. Out of the 21 Cancer Alliances in England, Cheshire and Merseyside ranks 6th for one-year cancer survival, 9th for five-year cancer survival, and 8th best for early stage diagnosis.

16. Cancer Alliance welcomes launch of game-changing cancer treatment

- 16.1 The Clatterbridge Cancer Centre has become the first NHS centre in Cheshire and Merseyside to offer Chimeric antigen receptor T-cell therapy – CAR-T therapy for short – a highly innovative form of immunotherapy. The treatment is very specialist and is only available in a few centres nationally for patients with specific cancers – including B cell lymphomas and acute lymphoblastic leukaemia (ALL) – that have not responded to other treatments or have returned after them. Until now, patients from Cheshire and Merseyside have had to travel to other parts of the UK to receive it, so this is great news that local patients can now access this treatment much closer to home.

17. Commercial Research Delivery Centre announcement

- 17.1 NHS University Hospitals of Liverpool Group (UHLG) has been named as host for an NIHR Commercial Research Delivery Centre, which will bring cutting-edge commercial research to communities in Cheshire and Merseyside.

⁸ <https://change.nhs.uk/en-GB/folders/in-case-you-missed-it>

- 17.2 As part of the NHS 10-year health plan, the Department of Health and Social Care (DHSC) has announced plans to establish 20 Commercial Research Delivery Centres (CRDCs), giving patients access to pioneering clinical trials and treatments in record time.
- 17.3 The Liverpool CRDC, funded as part of a £100m government private investment initiative, will support the rapid set-up of commercial studies, meaning patients can begin accessing treatments as part of clinical trials as early as possible. Alongside UHLG, the Centre will bring together Cheshire and Merseyside organisations including primary and social care; voluntary organisations and 10 secondary care organisations from the region.
- 17.4 Establishing the CRDC will mean even more studies and treatments will be available in areas including cancer, respiratory illness, obesity, and infectious diseases. Studies show that research-active hospitals and organisations achieve better health outcomes for patients, due to better understanding of the effects of treatments, ongoing care and monitoring as part of a research study.
- 17.5 The CRDC collaborative will allow health and research programmes across the region to continue to build on ground-breaking research, supported by specialist services

18. Key campaigns

- 18.1 **Stay Well this Winter.** NHS Cheshire and Merseyside’s ‘Stay Well this Winter’ campaign provides clear and practical messaging to empower patients, families and communities to support their relatives coming home from hospital and encourages people to play their part to stay well over winter – helping to ease pressure on the NHS. The campaign, which is running from November 2024 through to March 2025 and created together with NHS and Local Authority partners, also aims to raise awareness and understanding of the importance of vaccinations including flu, COVID-19 and RSV, and includes top tips for people to be winter ready.
- 18.2 The campaign supplements and compliments national and regional winter campaigns undertaken by NHS England and also winter messaging undertaken by our wider system partners. Campaign creatives are built around the concept of ‘Home’ as the centre of health and wellbeing and includes prevention and interventional messaging. Assets include engaging social media visuals with links to supporting information as well as short video ‘reels’ that feature real life experiences of people blended with expert views including the NHS Cheshire and Merseyside Medical Director, Professor Rowan Pritchard Jones. To date, the campaign has reached over 2.5million people across our ads
- 18.3 **Super Bodies campaign.** The ICB launched a campaign called ‘Super Bodies’ in winter 2024 across the Cheshire and Merseyside integrated care system. As Cheshire and Merseyside has high prescribing levels of antibiotics for children, and a large degree of variation across different areas, the behaviour-change



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campaign, designed to tackle the overuse of antibiotics in treating common winter illnesses (cough, ear ache, sore throat) was aimed at parents of young children.

- 18.4 Children are at risk of unnecessary exposure to antibiotics, particularly for viral respiratory tract infection, and antibiotic exposure in children can adversely affect the normal development of their immune system, increasing susceptibility to infections in later life. Reducing unnecessary prescribing of antibiotics will also reduce costs and wasted resources for the system.
- 18.5 The campaign was rolled out across Cheshire and Merseyside partners and is now being shared nationally by other ICBs.
- 18.6 **Medicines Waste campaign.** The ICB also launched in November 2024 a communications campaign called ‘Only Order What You Need’ in November 2024, aiming to reduce unnecessary over-ordering and waste of prescription medications. The campaign concludes at the end of January 2025. The theme of the campaign is around educating and empowering patients in a positive way, sharing the benefits to avoid wasting medication and techniques to do so, and employs a three-phase approach:
- only order what you need
 - safe disposal of medication and inhalers
 - taking medication into hospital when admitted.
- 18.7 **Self-Care Week.** The ICB hosted a comprehensive week of self-care activities for staff to mark national self-care week, international men’s day and carers rights day in November. There were over 430 participants across the ten events that ran across the week with positive evaluations from participants and new recruits to our various staff networks. This work is being further developed and aligned as part of our staff Health and Wellbeing programme for 2025.
- 18.8 **LGBTQ+ history month.** The NHS Cheshire and Merseyside LGBTQ+ Network is holding an all-staff session for LGBTQ+ History month on 13 February 2025. The session will include guest speakers who will share their experiences with staff.

19. Good News and Congratulations

- 19.1 **New Years Honours.** Congratulations to all those across health and care in Cheshire and Merseyside who were fortunate enough to be recognised in the New Years Honours list. In particular, it was good to see that Kathryn Thomson, the former Chief Executive at Liverpool Women’s Hospital, receive an MBE for services to health, having been in the NHS for over 40 years. The full list of the recipients of New Year Honours from across Cheshire and Merseyside can be found at:

<https://www.cheshireandmerseyside.nhs.uk/posts/health-and-care-leaders-among-those-recognised-in-2025-new-year-honours-list/>.

20. Decisions taken at the Executive Committee

- 20.1 Since the last Chief Executive report to the Board in November 2024, the following items have been considered by the Executive Team for decision:
- **Inflationary Uplift proposals** – the Executive Committee received a paper outlining proposed inflationary uplifts for those contracts the ICB has for services for which the NHD Payment Scheme does not mandate an NHSPS unit price. It was confirmed that the minimum uplifts specified within the paper a report for the existing ICB financial budget forecast, there if accepting the proposals it would not worsen the ICB forecast. The Committee approved the proposed uplifts, with some minor edits, and approved the adoption of the principles for future year uplifts, which would prevent the need for further review in future years, subject to affordability.
 - **Living Well Bus** – the Executive Committee received a paper regarding the continued funding of the Living Well Bus, outlining how it had been historically funded and that confirmation regarding NHS England Access and Inequalities funding for 2025/25 had not yet been confirmed. The Committee approved the recommendation for the ICB to underwrite the cost of the service for 2025/26 until confirmation of the NHS England funding was confirmed.
 - **Long Covid Services** – the Committee considered a paper on the issues and challenges faced with the long term sustainability of the six separate services currently in place across Cheshire and Merseyside which support the management of long covid. Due to a significant drop in referrals and the expected loss of the ring-fenced national funding, the Committee agreed to no longer commission the six hub based long covid services and to cease making referrals into these services. It was agreed that the ICB will undertake a commissioning review to identify and agree the best way of supporting people with Long Covid to ensure they continue to receive the appropriate care and support in the future. In the meantime, patients who need Long Covid support will be referred to other existing services relevant to their clinical need.
 - **Remote Tier 3 Weight Management Services** – the Committee considered and approved the publication of an interim Commissioning Policy for Remote Tier 3 Weight Management Services^[1] and which describes the referral criteria and requirements of any services of this nature. This includes a requirement that any provider of specialist weight management services should be able to offer our residents the option of a local face-to-face appointment alongside digital or remote services. This is to ensure that there is no inequality in access to services for patients without access to or confidence in using digital services. This will be reviewed as the ICB progresses work to recommission local Tier 3 services able to meet the national NICE technology appraisals in relation to management of overweight and obesity.
 - **Decommissioning panel** – the Committee received a paper outlining the work undertaken to develop and approve the ICBs Decommissioning policy and a proposed framework for the management of the application of the

^[1] <https://www.cheshireandmerseyside.nhs.uk/media/n4qlaqwr/remote-access-policy-specialist-weight-management-services.pdf>

policy. The Committee agreed the recommendation for the ICB to establish a Decommissioning Panel.

20.2 At its meetings throughout December 2024 and January 2025, the Executive Committee has also considered papers on or discussed the following areas:

- All Age Continuing Care Programme Update
- Board Assurance Framework and Corporate Risk Register
- Children’s change and integration programme
- Vacancy control Updates
- ICB Workforce review
- Recovery decommissioning
- C&M Neurodiversity programme update
- Operating Model
- Winter pressures
- Health and Care Partnership.

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

21. Officer contact details for more information

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22. Appendices

Appendix One: Summary of Specialised Commissioning Delegation Arrangements from 01 April 2025

Appendix Two: Specialised Commissioning Delegation Agreement: Variation Proposal

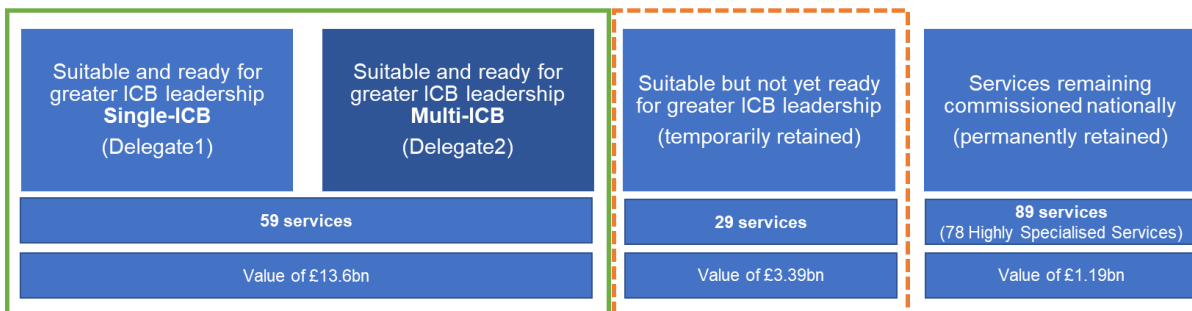
Appendix Three: Covid-19 and Flu vaccination uptake by Cheshire and Merseyside NHS Trust

Appendix One:

Summary of Specialised Commissioning Delegation Arrangements – 01 April 2025

1. Introduction

- 1.1 The Health and Care Act 2022 (the Act) provided new powers for NHSE to delegate its direct commissioning functions to Integrated Care Boards (ICBs). Under delegation, whilst NHSE will retain overall accountability for the discharge of its responsibilities under the Act, the liability for the delegated functions shifts to ICBs as the bodies responsible for discharging them.
- 1.2 In February 2024, the NHS England Board approved plans to fully delegate the commissioning of appropriate specialised services to Integrated Care Boards (ICBs) in the East of England, Midlands and the North West (NW) regions of England from April 2024. These 59 services were identified in The Roadmap to integrate specialised services of care within Integrated Care Systems¹.
- 1.3 To support this, work was undertaken in the North West to support delegation of a 'segmentation of services' that are listed as being 'ready and suitable for ICS delegation'. This segmentation has examined the natural planning footprints for these services based on patient flows and categorised them as being suitable for decision making at single-ICS level; and those that will require multi ICS collaboration across all three NW ICSs. The segmentation of services is described as follows:



- 1.4 At the March 2024 NHSE Board Meeting², a decision was taken on the list of 25 'amber' services that were suitable but not ready for delegation to ICBs in 2024/25. A decision was taken on to either delegate the service to ICBs from April 2025 or to retain the commissioning responsibility within NHS England permanently. The proportion of spend for services that have either been delegated or are ready for ready for delegation is around 60% of the total Specialised Services spend. A full list of services within the scope of delegation from April 2025 is included in section 4.5.
- 1.5 To enable support the delegation of specialised services, a Cheshire and Merseyside Specialised Commissioning Oversight Group and North West Specialised Services Joint Committee has been established to carry out strategic decision-making, leadership and oversight functions relating to the commissioning of specified Delegated Services.

¹ [PAR1440-specialised-commissioning-roadmap-addendum-may-2022.pdf \(england.nhs.uk\)](#)

² [NHS England » Specialised Commissioning – update on specialised services for delegation](#)

2. The NW Specialised Commissioning Hub

2.1 A national operating model has been developed to ensure:

- Geographically-facing hubs will be established to coordinate provider relationships consistently between Delegated and Retained Specialised Services and will be a vehicle for engaging/consulting ICBs on retained commissioning issues.
- Only NHS England employees will be able to access NHS England systems (including the Ledger)
- Only NHS England employees will be able to take decisions that commit NHSE resources
- The assurance of delegated specialised commissioning will only be done by people that do not deliver delegated commissioning activities.
- The resource required for delivering retained specialised commissioning will remain with NHS England is identified.

2.2 To reduce duplication (e.g. contract building), staff will work as a team to ensure that single staff members can undertake commissioning tasks for both retained and delegated elements across the NW regional. The Hub will deliver a shared service to the three NW ICB. The quality team for the hub will contribute the specialised service dimension into local ICB quality processes e.g. RQR; SQG etc. Service-specific knowledge and expertise will be shared across both delegated and retained portfolios. However, NHS England NW Region will host a separate Finance Team that will manage the budgets for retained Specialised Services for the North West and North East and Yorkshire regions.

2.3 Work has been undertaken to determine and consult on which roles and individuals will be in scope to transfer to the ICBs and which roles and individuals will be in scope to remain with NHS England. Formal outcome of consultation notifications letters were sent to staff on 2 December 2024.

3. Finance and Contractual Arrangements

3.1 The ICB will receive direct allocations to commission specialised services for its population. The NW Specialised Commissioning Hub will provide a financial management service for this allocation. The Hub will work with the ICBs to develop and agree a financial plan. Key Financial Issues will be discussed and agreed through the finance sub-group. All Financial decisions will be agreed in line with each ICBs financial governance for single ICB services. For those multi IBC services financial decisions will be agreed via the joint commissioning committee. The hub will monitor and report delivery of this plan into the ICBs. The hub will prepare financial schedules to support payments for specialised commissioning services. All payments are agreed and approved by the ICBs.

3.2 It has been agreed via the North West Finance sub-group that from April 2025, contracting for delegated services along with retained specialised services and other NHS England non specialised services (health and Justice, Armed Forces and Section 7a) will be included within the ICB contract. Work has commenced with the regional contract leads to set out an operating model to support these arrangements with the hub continuing to undertake contract negotiation and management of the specialised elements of the contract whilst minimising duplication where appropriate. To support these arrangements although not mandated, it is also proposed that Collaborative Commissioning Agreements (CCA) are agreed. CCA's set out clear responsibilities for parties to the contract.

4. The Delegation agreement

- 4.1 In April 2024, the three NW ICB's implemented delegated arrangements using the specialised services delegation agreement. The Delegation Agreement enacts the delegation and transfers statutory commissioning responsibility for delegated specialised services from NHSE to each individual ICB. The NW Delegation Agreement allowed all three ICBs to form multi-ICB arrangement and support the NW Specialised Commissioning hub.
- 4.2 Since the delegation agreement was finalised, further development work across the programmes preparing for delegation of the remaining services, functions and remaining ICBs, means that it is necessary to vary the existing delegation agreements in advance of April 2025.
- 4.3 The list of areas that have required amendment are:
- NHS England Core Design Principles.
 - Functions relating to Mental Health, Learning Disability and Autism Specialised Services.
 - Commissioning and optimisation of high cost drugs.
 - Complaints functions.
 - Updated definition of population.
 - Clarify NHS England responsibilities for specialised top-up payments.
 - Contracting Standard Operating Procedure.
 - Minor corrections.
 - Updated list of delegated specialised services for April 2025.
 - Schedule 6: further information governance, sharing and processing provisions.
- 4.4 The variation proposal presented at Appendix 2. This document contains the amendments that are required to the delegation agreement to comply with Clause 26 (variations) of the existing agreement.
- 4.5 The tables on the following pages show the NW Specialised Service Segmentation as to which geographrapic footprint services are commissioned at, this reflects:
- The natural planning footprints for specialised services in the NW region based on patient flows.
 - The services are categorised within national 'Programmes of Care' are being suitable for decision making at single-ICS level; and those that will require multi ICS collaboration across all three NW ICBs and at North of England (supra-regional) level.
 - Specialised Services that will be retained as a national NHS England commissioning responsibility are also listed.

Programme of Care	ICS Level	North West Level	Supra-Regional	National (T4)
Internal Medicine	Cardiac Surgery Cardiac ICD/CRT Cardiac MRI Cardiac EP and Ablation Cardiac PPCI Vascular Surgery Complex IBD Faecal Incontinence Colorectal TEMS Surgery Acute Kidney Injury Assessment for Dialysis Renal Dialysis (Hospital) Renal Dialysis (Home) Renal Dialysis (Peritoneal)	Cystic Fibrosis (Adult) Cystic Fibrosis (Children) Hepatobil & Pancreas (A) Pancreatic Cancer (A) Anal Cancer (Adult) Intestinal Failure (A) Spc Endocrinology (A) Spc Rheumatology (A) Spc Dermatology (A) Skin Cancer (Adult) Interstitial Lung Disease Complex Ventilation Severe Asthma Renal Transplantation Distal Sacrectomy (A) ACHD	Pulmonary Hypertension	Liver Transplant (Adult) Small Bowel Transplant (A) Sclerosing Peritonitis Surg Auto Intestinal Reconstruct Pseudomyxoma Peritonei Pulmonary Thromboendart. Epidermolysis Bullosa Xeroderma Pigmentosum Behcets Syndrome Complex Ehlers Danlos Ataxia Telangiectasia (A) Chronic Pulmonary Aspergillosis Congenital Hyperinsulinism Insulin Resistant Diabetes Islet Cell Transplantation Pancreas Transplantation Alstrom Syndrome Bardet-Biedl Syndrome Wolfram Syndrome Ventricular Assist Devices Heart & Lung Transplant

Programme of Care	ICS Level	North West Level	Regional (T3)	National (T4)
Cancer	OG Cancer (Adult) Kidney Blad Prostate Cancer Chemotherapy (Adult) PET-CT Head & Neck Cancer (Ad)	Radiotherapy Brachytherapy Malignant Mesothelioma Soft Tissue Sarcoma (Adult) CNS Cancers (Adult) Penile Cancer (Adult) Testicular Cancer (Adult) Chemotherapy (TYA) TYA Cancer		Breast Radiotherapy Injury Proton Beam Therapy Primary Bone Cancers Complex NF Type 1 NF Type 2 Ex-vivo Partial Nephrectom

Programme of Care	ICS Level	North West Level	Supra-Regional	National (T4)
Blood & Infection	HIV (Adult) Spc Immunology Spc Allergy	HSCT (Adult) HSCT (Children) Haemoglobinopathy Haemophilia HIV (Children) Spc Infectious Diseases (A) Tropical Medicine Bone & Joint Infection		SCIDS Atyp Haeomlytic Uremic S Parox Nocturnal Haemogl HTLV I & II High Secure Infectious Dis.

Programme of Care	ICS Level	North West Level	Supra-Regional	National (T4)
Trauma, Head and Neck	Specialised Rehab Neurosurgery (Adult) Spc Neurosciences Spc Orthopaedics Spc Ophthalmology (Adult) Spc Ophthalmology (Child) Complex Spinal Surgery Major Trauma Implantable Hearing Aids (BAHA)	Critical Care (Adult) Communication Aids Environmental Controls Prosthetics Stereotactic Radiosurgery Specialised Burns Cleft Lip & Palate Specialised Pain Cochlear Implants	Hyperbaric Oxygen Therapy Spinal Cord Injuries Middle Ear Implant Aids	Hand Transplantation Artificial Eyes (Implants) Rare Neuromuscular Neuromyelitis Optica Ocular Oncology Ophthalmic Pathology OOKP Stickler Syndrome ECMO (Respiratory) (Adult)

Programme of Care	ICS Level	North West Level	Supra-Regional	National (T4)
Mental Health	Inpatient Eating Disorders Medium Secure MH Low Secure MH CAMHS: Adolescent CAMHS: Eating Disorders CAMHS: Psych ICU CAMHS: ASD CAMHS: Learning Disability	Tier 4 Personality Disorders Gender Identity Clinical Perinatal Mental Health CAMHS: Low Secure	Gender Identity Surgery CAMHS: Children	High Secure Mental Health Deaf Mental Health Deaf CAMHS Severe OCD and BDD Veterans PTSD Secure Forensic CAMHS

Programme of Care	ICS Level	North West Level	Supra-Regional	National (T4)
Women's & Children's	Paed Rheumatology Paed Endocrinol & Diabetes Paed Respiratory Paed Allergy (please see adult allergy slide) Neonatal Critical Care Gynae: Endometriosis Gynae: Urogenital/Anorectal Gynae: Incontinence/Prolap Gynae: Cancer	Paed Surgery Paed Chronic Pain Neonatal Surgery Paediatric Renal Paed Gastro Hep & Nutrit Paed Immunol & Infection Paed Haematology Perinatal Pathology Paed Palliative Care Paed Oncology Paed Intensive Care Paed High Dependency Paed Long Term Ventilation PIC Retrieval NIC Retrieval Paed Neurosurgery Paed Neurology Paed Neurodisability Paed Neurorehabilitation Gynae: Congenital Abnorm Gynae: Urinary Fistulae Fetal Medicine	Paediatric Cardiol & Surg Metabolic Disorders (Adult) Metabolic Disorders (Child) Metabolic Disorders (Labs)	Medical Genetics Beckwith Wiedemann Bladder Exstrophy Complex Tracheal Surgery Craniofacial Surgery Liver Transplant (Child) Small Bowel Transplant (C) Spc Liver Disease (C) Retinoblastoma Paed Pulmonary Hypertens Alkaptonuria Barth Syndrome LSDs Epilepsy Surgery (Child) Ataxia Telangiectasia (C) Vein of Galen Malformation Choriocarcinoma Osteogenesis Imperfecta CAPS Amyloidosis 1ry Ciliary Diskenesia (C) Rare Mitochondrial Disorders McArdles Disease Severe Acute Porphyria Paediatric Gender Identity

Appendix Two - Specialised Commissioning Delegation Agreement: Variation Proposal



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Introduction

In December 2023, the NHS England board approved the delegation of 59 specialised services to integrated care boards (ICBs). In April 2024, 20 ICBs in three NHS England regions implemented delegated arrangements using the specialised services delegation agreement.

The template document was prepared by the specialised commissioning strategy and policy team and NHS England legal team, with key input from across the Future Commissioning Models Programme (FCMP) and the ICS Implementation Programme (ICSIP).

The delegation agreements for 2024 were signed by NHS England regional directors and representatives of the ICB, following consideration and approval by ICB boards. They came into effect on 1 April 2024.

This guidance document only applies where NHS England regional teams and ICBs implemented a delegation agreement from April 2024. For those regional teams and ICBs that are implementing delegation of specialised services from April 2025, please see the separate delegation agreement template for April 2025.

Since the delegation agreement was finalised, further development work across the programmes preparing for delegation of the remaining services, functions and remaining ICBs, means that it is necessary to vary the existing delegation agreements in advance of April 2025.

The list of areas that have required amendment are:

- NHS England Core Design Principles.
- Functions relating to Mental Health, Learning Disability and Autism Specialised Services.
- Commissioning and optimisation of high cost drugs.
- Complaints functions.
- Updated definition of population.
- Clarify NHS England responsibilities for specialised top-up payments.
- Contracting Standard Operating Procedure.

- Minor corrections.
- Updated list of delegated specialised services for April 2025.
- Schedule 6: further information governance, sharing and processing provisions.

This document contains the amendments that are required to the delegation agreement. In 'the variation proposal' it also contains the Variation Proposal that regions and ICBs can use to vary their delegation agreements and comply with Clause 26 (variations) of the agreement.

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The variation proposal

To ensure that existing delegation agreements are up-to-date and reflect the latest changes required by the programmes, this document sets out the wording that should be changed in local delegation agreements.

To ensure the process is as straightforward as possible, this document can be used as a Variation Proposal under Clause 26 of the specialised services delegation agreement.

Regional teams are advised to complete the details in the following box. Once these have been completed, the Variation Proposal can be issued to ICB colleagues.

This guidance document sets out the amendments to the specialised services delegation agreement between NHS England and Greater Manchester Integrated Care Board ICB dated 15th January 2025.

It is NHS England's intention to vary the agreement in accordance with Clause 26 and as set out in this document. Therefore, this document constitutes NHS England's Variation Proposal to the ICB.

The date on which the Variation Proposal is to take effect is 1 April 2025. This Variation Proposal is issued on 15th January 2025. The ICB has 30 Operational Days (which do not include Saturday, Sunday or Bank Holidays) to consider the Variation Proposal.

By 26th February 2025, in accordance with Clause 26.7, the ICB should give notice to NHS England as follows:

- a) that it accepts the Variation Proposal; or
- b) that it refuses to accept the Variation Proposal and setting out reasonable grounds for that refusal.

If the Variation Proposal is not accepted, local resolution should be attempted before the procedure at Clause 15 (*escalation rights*) is instigated.

If the Variation Proposal is accepted, this document should be signed by an appropriate representative of the NHS England regional team and the ICB in the signature box below. Once signatures are added and dated, this will formalise the variation to the delegation agreement. Accordingly, any organisational governance processes, such as approval by the ICB Board (if required), should be sought before the Variational Proposal is signed.

Additionally, the existing delegation agreement can be updated to include the amended text and stored in accordance with organisational policies for records management.

NHS England and [INSERT NAME [ICB]] agree to vary the specialised services delegation agreement dated [INSERT DATE] as set out in this Variation Proposal.

Signed on behalf of NHS England:	Signed on behalf of the ICB:
Name:	Name:
Role:	Role:
Date:	Date:
Signature:	Signature:

NHS England Core Design Principles

Three Core Design Principles have been developed and were agreed by NHS England's Executive Group on 15 October 2024. These are that NHS England's staff will:

- a. Not mak[e] statutory or financial decisions that allocate NHS England resources unless [they] are employed by NHS England, or that allocate ICB resources unless [they] are employed by an ICB.
- b. Not access a ledger or other finance systems, or use data directly obtained from the ledger or other finance systems for an organisation [they] are not substantively employed by.
- c. Not have accountability for NHS England's oversight and assurance of delegated commissioning if [they] hold responsibility for strategic decision making in respect of delegated commissioning delivery.

A series of amendments are proposed to ensure that the delegation agreement reflects these Principles. The following sections describe the changes that need to be made.

Clause 6 – Delegation

At Clause 6 (Delegation) after Clause 6.4 **insert:**

- 6.5 To the extent that this Agreement applies:
 - 6.5.1 The ICB must ensure that its officers or employees do not make statutory or financial decisions that allocate NHS England resources.
 - 6.5.2 NHS England must ensure that its officers or employees do not make statutory or financial decisions that allocate ICB resources, except as provided for in this Agreement.

[ENDS]

As this is an insertion of a new clause, the subsequent clauses should be renumbered.

At the newly renumbered Clause 6.6 after the words '...the ICB is not authorised...' **delete:**

by this Agreement

At the newly renumbered Clause 6.7 after the words 'that the impact of the ICB decision could' **delete:**

, in relation to the Delegated Functions,

At the newly renumbered Clause 6.8 after the words 'The terms of Clauses' **delete:**

6.5 and 6.6

And **insert:**

6.5, 6.6 and 6.7

[ENDS]

Clause 9 – Performance of the Reserved Functions and Commissioning Support Arrangements

At Clause 9 after Clause 9.8 **insert:**

9.9 Any arrangement made between the ICB and NHS England under Clauses 9.5 or 9.7 must be made in accordance with: Clause 6.5, Clause 10.14 and Paragraph 4.2 of Schedule 4.

ENDS

Clause 14 – Finance

At Clause 14 (Finance) after clause 10.13.2 **insert:**

Ledger access and use of financial data

10.14 NHS England and the ICB agree that they shall not access a financial ledger or other finance system that is operated by another organisation, or use data directly obtained from such a financial ledger or other finance system.

10.15 Clause 10.14 applies unless that access or use has been approved in advance by the organisation that operates that financial ledger or other finance system, or as is otherwise expressly provided for in this Agreement.

ENDS

As this is an insertion of new clauses, the subsequent clauses should be renumbered.

- 10.14 should read 10.16.
- 10.15 should read 10.17.
- 10.16 should read 10.18.

Schedule 4 (Retained Functions), Paragraph 4 (Assurance and Oversight)

At Paragraph 4 (Assurance and Oversight) of Schedule 4 (Retained Functions) after sub-paragraph 4.1.6 **insert:**

4.2 Where an officer or employee of NHS England is performing its Reserved Functions in respect of assurance and oversight, NHS England must ensure that those officers or employees do not hold responsibility for, or undertake any, decision making in respect of the ICB's Delegated Functions.

ENDS

Core Design Principles: consequential amendments

Clause or paragraph number	Change required
10.17.7	Replace '10.15.3' with '10.17.3'.
Clause 14.2.2	Replace 'Clause 6.5' with 'Clause 6.6'.
Clause 14.2.3	Replace 'Clause 6.6' with 'Clause 6.7'.
Clause 15.3	Replace 'Clause 6.6' with 'Clause 6.7'.

Mental health, learning disability and autism specialised services

From April 2025, the delegation of specialised service will include mental health, learning disability and autism (MHLDA) services. These were agreed by the NHS England Board in March 2024 and the service lines are set out as amendments to Schedule 2 (delegated services) (see below). As examples, this will include the specified low and medium secure adult specialised mental health services (see PSS Manual Code 6).

To support the delegation of these services, it is proposed that further changes are made to Schedule 3 (ICB delegated functions) and Schedule 4 (NHS England's retained services).

This section describes the changes.

Schedule 3 – delegated functions

In Schedule 3 (delegated functions) at paragraph 16 after 'Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives' **delete:**

The ICB shall co-operate fully with NHS England in the development, management and operation of mental health, learning disability and autism NHS-led Provider Collaboratives including, where requested by NHS England, to consider the Provider Collaborative arrangements as part of the wider pathway delivery.

and **insert:**

- 16.1. The ICB will oversee the lead provider contract(s) relating to mental health, learning disability and autism (MHLDA) Provider Collaboratives that are transferred to the ICB on 1 April 2025 by NHS England. This includes complying with all terms and conditions of the contract(s), including in respect of notice periods and extensions.
- 16.2. If the ICB proposes to terminate a MHLDA lead provider contract before the end of its term, it must seek written approval from NHS England in advance.

- 16.3. In the performance of its commissioning responsibilities for MHLDA Specialised Services, the ICB shall:
- 16.3.1. Have regard to any commissioning guidance relating to MHLDA Specialised Services issued by NHS England;
 - 16.3.2. Comply with the requirements of the Mental Health Investment Standard and related guidance issued by NHS England;
 - 16.3.3. Generally have regard to the need to commission MHLDA Specialised Services for the ICB's Population in such a manner as to ensure safe, efficient and effective services, across appropriate geographies, and which may require partnership working across other ICB or other organisational boundaries.
 - 16.3.4. Ensure that its case management function will work collaboratively across Delegated Services and Retained Services to support the oversight and progression of individual patient care, including the movement across elements of the care pathway.

[ENDS]

In Schedule 3 (delegated functions) at paragraph 16 in the title 'Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives' **delete:**

NHS-led Provider Collaboratives

And **insert:**

Specialised Services

[ENDS]

Schedule 4 – retained functions

In Schedule 4 (retained functions) at paragraph 17 after 'Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives' **delete:**

NHS England shall commission and design NHS-led Provider Collaborative arrangements for mental health, learning disability and autism services. Where it considers appropriate, NHS England shall seek the input of the ICB in relation to relevant Provider Collaborative arrangements.

and **insert:**

- 17.1. NHS England shall issue commissioning guidance for MHLDA Specialised Services in relation to the Delegated Services and Retained Services.
- 17.2. NHS England shall prepare and issue National Specifications and Clinical Commissioning Policies for MHLDA Specialised Services.
- 17.3. NHS England will monitor the ICB's compliance with the Mental Health Investment Standard in respect of MHLDA Delegated Services.
- 17.4. NHS England shall ensure that its case management function will work collaboratively across Delegated Services and Retained Services to support the oversight and progression of individual patient care, including the movement across elements of the care pathway.

[ENDS]

In Schedule 4 (retained functions) at paragraph 17 in the title 'Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives' **delete:**

NHS-led Provider Collaboratives.

And **insert:**

Specialised Services

[ENDS]

Commissioning and optimisation of high cost drugs

Amendments have been proposed to both the ICB and NHS England functions relating to the commissioning and optimisation of high cost drugs. This is partly to overcome some concerns raised that the responsibilities of the respective organisations were not clear enough in the 2024 delegation agreement; but also, to update the text to reflect changes in the operating models that have been developed in year.

It is proposed that changes are made to Schedule 3 (ICB delegated functions) and Schedule 4 (NHS England's retained services). Given the range of changes and to make the amendments more straightforward, colleagues are advised to replace the text in these sections in its entirety.

Schedule 3 – delegated functions

In Schedule 3 (delegated functions) at paragraph 8 after the title 'Commissioning and optimisation of High Cost Drugs' **delete** paragraphs 8.1 to 8.8.

And **insert**:

- 8.1 The ICB must support the effective and efficient commissioning of High Cost Drugs for Delegated Services.
- 8.2 The ICB must support NHS England in its responsibility for the financial management and reimbursement of High Cost Drugs for Specialised Services. The ICB and NHS England must agree the support to be provided. The support must be set out in writing and may include staffing, processes, reporting, prescribing analysis and oversight arrangements, but is not limited to these matters.
- 8.3 The ICB must ensure equitable access to High Cost Drugs used within the Delegated Services that may be impacted by health inequalities and develop a strategy for delivering equitable access.
- 8.4 The ICB must develop and implement Shared Care Arrangements across the Area of the ICB.
- 8.5 The ICB must provide clinical and commissioning leadership in the commissioning and management of High Cost Drugs.

- 8.6 The ICB must ensure:
- 8.6.1 safe and effective use of High Cost Drugs in line with national Clinical Commissioning Policies, NICE technology appraisal or highly specialised technologies guidance;
 - 8.6.2 effective introduction of new medicines;
 - 8.6.3 compliance with all NHS England commercial processes and frameworks for High Cost Drugs;
 - 8.6.4 Specialised Services Providers adhere to all NHS England commercial processes and frameworks for High Cost Drugs;
 - 8.6.5 appropriate use of Shared Care Arrangements, ensuring that they are safe and well monitored; and
 - 8.6.6 consistency of prescribing and unwarranted prescribing variation are addressed.
- 8.7 The ICB must engage in the development, implementation and monitoring of initiatives that enable use of better value medicines. Such schemes include those at a local, regional or national level.
- 8.8 Where the relevant pharmacy teams have transferred to the ICB or Host ICB, the ICB must provide:
- 8.8.1 support to prescribing networks and forums, including but not limited to, Immunoglobulin Assessment panels, prescribing networks and medicines optimisation networks;
 - 8.8.2 expert medicines advice and input into the Individual Funding Request process for Delegated Services;
 - 8.8.3 advice and input to national procurement and other commercial processes relating to medicines and High Cost Drugs (for example, arrangements for Homecare);
 - 8.8.4 advice and input to NHS England policy development relating to medicines and High Cost Drugs.

[ENDS]

Schedule 4 – reserved functions

In Schedule 4 (reserved functions) at paragraph 9 after the title ‘Commissioning and optimisation of High Cost Drugs’ **delete** paragraphs 9.1 (inclusive of sub-paragraphs).

And **insert**:

- 9.1. Unless otherwise agreed with the ICB, NHS England shall manage a central process for reimbursement of High Costs Drugs for Specialised Services. This may include making reimbursements directly to Specialised Services Providers.
- 9.2. In respect of pharmacy and optimisation of High Cost Drugs, NHS England shall:
 - 9.2.1. where appropriate, ensure that only validated drugs spend is reimbursed, there is timely drugs data and drugs data quality meets the standards set nationally;
 - 9.2.2. support the ICB on strategy for access to medicines used within Delegated Services, minimising barriers to health inequalities;
 - 9.2.3. provide support, as reasonably required, to the ICB to assist it in the commissioning of High Cost Drugs for Delegated Services including shared care agreements;
 - 9.2.4. seek to address consistency of prescribing in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation;
 - 9.2.5. develop medicines commissioning policies and criteria for access to medicines within Specialised Services;
 - 9.2.6. develop support tools, including prior approval criteria, and frameworks to support the delivery of cost-effective and high quality commissioning of High Cost Drugs;
 - 9.2.7. co-ordinate the development, implementation and monitoring of initiatives that enable the use of better value medicines;
 - 9.2.8. where appropriate, co-ordinate national procurement or other commercial processes to secure medicines or High Cost Drugs for Specialised Services.

[ENDS]

Complaints functions

During 2024/25, complaints functions relating to the delegated services have remained with NHS England. From 1 April 2025, all complaints received relating to the delegated services will be handled by ICBs. To support this, amendments need to be made to both Schedule 3 (delegated functions) and Schedule 4 (reserved functions). A related amendment is proposed for Schedule 1 (definitions) to include a missing definition.

Schedule 1 – definitions

In Schedule 1 (definitions) after “Commissioning Team Agreements” **insert:**

“Complaints Sharing Protocol” has the definition given in paragraph 7.5 of Schedule 3;

Schedule 3 – delegated functions

In Schedule 3 (delegated functions) at paragraph 7 after the title ‘Complaints’ **delete** paragraphs 7.1 to 7.4.

And **insert:**

- 7.1 This part (*Complaints*) applies from the Effective Date of Delegation or the date on which the Commissioning Team is transferred to the relevant Host ICB (whichever is the later) (“the Applicable Date”).
- 7.2 The ICB will be responsible for all complaints in respect of the Delegated Services that are received from the Applicable Date, regardless of whether the circumstances to which the complaint relates occurred prior to the Applicable Date.
- 7.3 For the avoidance of doubt, NHS England will retain responsibility for all complaints in respect of the Delegated Services that were received prior to the Applicable Date.
- 7.4 At all times the ICB shall operate in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

and shall co-operate with other ICBs to ensure that complaints are managed effectively.

- 7.5 Where NHS England has provided the ICB with a protocol for sharing complaints in respect of any or all Specialised Services then those provisions shall apply and are deemed to be part of this Agreement (the “Complaints Sharing Protocol”).
- 7.6 The ICB shall:
- 7.6.1 work with local organisations, including other ICBs that are party to the ICB Collaboration Arrangement or Commissioning Team, to ensure that arrangements are in place for the management of complaints in respect of the Delegated Services.
 - 7.6.2 consider, in the context of the ICB Collaboration Arrangement for the commissioning of the Delegated Services and employment arrangements for the Commissioning Team, whether it is best placed to manage the complaint, or whether it should be transferred to another ICB that is better placed to affect change.
 - 7.6.3 provide the relevant individuals at NHS England with appropriate access to complaints data held by the ICB that is necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.
 - 7.6.4 Provide such information relating to key performance indicators (“KPIs”) as is requested by NHS England.
 - 7.6.5 co-operate with NHS England in respect of the review of complaints related to the Delegated Services and shall, on request, share any learning identified in carrying out the complaints function.
 - 7.6.6 take part in any peer review process put in place in respect of the complaints function.

[ENDS]

Schedule 4 – reserved functions

In Schedule 4 (reserved functions) at paragraph 8 after the title ‘Complaints’ **delete** paragraphs 8.1 to 8.4.

And insert:

- 8.1. NHS England shall manage all complaints in respect of the Delegated Services that are received prior to the Effective Date of Delegation or the date on which the Commissioning Team is transferred to the Host ICB (whichever is the later).
- 8.2. NHS England shall provide the relevant individuals at the ICB with appropriate access to complaints data held by NHS England that is necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.
- 8.3. NHS England shall manage all complaints in respect of the Retained Services.
- 8.4. NHS England shall set out what information the ICB is required to provide when reporting on the key performance indicators. NHS England should notify the ICB in advance and provide sufficient time to allow compliance.

[ENDS]

Contracting Standard Operating Procedure

A minor addition is proposed to the contracting section of Schedule 3 (delegated services) to link the Contracting Standard Operating Procedure, which is already referred to in the delegated agreement under the list of finance guidance, to the contracting section. This is intended to make it clearer to the reader that there is linked guidance.

Schedule 3 – delegated functions

In Schedule 3 (delegated functions) after paragraph 9.1 (and sub-paragraph 9.1.3) **insert:**

- 9.2 The ICB must comply with the Contracting Standard Operating Procedure issued by NHS England.

[ENDS]

DRAFT

General amendments

There are two amendments required to existing specialised commissioning delegation agreements to correct for errors in the document. These are:

- a) To amend the definition of 'Population' in Schedule 1 (definitions and interpretation);¹ and
- b) To introduce NHS England functions relating to prescribed specialised services top-up payments in respect of delegated services to Schedule 4 (reserved functions).²

Guidance notes were issued in March 2024 on both of these amendments and which are available on the Future Commissioning Model Programme (FCMP) Future NHS site.³ Full background information on the amendments is contained within the guidance notes.

Definition of ICB Population

In Schedule 1 (definitions and interpretation) at the definition 'Population' **delete:**

means the individuals for whom the ICB has responsibility in respect of commissioning the Delegated Services;

and **insert:**

means, in relation to any particular delegated service, the group of people for which the ICB would have the duty to arrange for the provision of that service under section 3 of the NHS Act (hospital and other services), if it was not a service which NHS England had a duty to arrange under its Specialised Commissioning Functions;

For guidance on the persons for whom an ICB is responsible for arranging services see *Who Pays? Determining which NHS commissioner is responsible for commissioning healthcare services and making payments to providers*;

¹ See: <https://future.nhs.uk/NationalSpecialisedCommissioning/view?objectID=201089765>

² See: <https://future.nhs.uk/NationalSpecialisedCommissioning/view?objectID=201089925>

³ See: <https://future.nhs.uk/NationalSpecialisedCommissioning/view?objectID=52249616>

[ENDS]

Prescribed Specialised Services Top-Up Payments

At Schedule 4 (Reserved Functions) at Paragraph 12 (Finance), **insert** the following text after Paragraph 12.1:

12.2 NHS England shall:

12.2.1 hold the budgets for prescribed specialised services top-up payments for specialist centres;

12.2.2 administer the top-up payments schemes; and

12.2.3 make top-up payments to the Specialised Services Providers.

12.3 For the avoidance of doubt, the functions set out in 12.2 include top-up payments for the Delegated Services and Retained Services

[ENDS]

Minor corrections

During the review of the delegation agreement for specialised services the following errors were found and can be corrected in the existing delegation agreements as part of the variation process.

Clause or paragraph number	Change required
Clause 1.2.2	<p>Incorrect numbering of clauses.</p> <p>Change “Clauses 2 to 31” to read “Clauses 2 to 32”.</p>
Clause 7.3.3	<p>Missing legislation reference.</p> <p>After ‘Section 14Z32 to Section 14Z44’ insert ‘of the NHS Act’.</p>
<p>Newly renumbered clauses: 10.16 and 10.17.</p>	<p>These clauses appear in the section entitled ‘pooled funds’ and will have been renumbered due to the additions of the Core Principles.</p> <p>At 10.17 move ‘NHS England and one or more ICBs in accordance with section 65Z5 of the NHS Act.’ to sub-clause 10.16.4. (You may need to add this numbering).</p> <p>Ensure that 10.17 starts with the following text: ‘Where the ICB has decided to enter into arrangements under Clause 10.16 the agreement must be in writing and must specify: ’</p>
Clause 11.1.1	<p>Typo.</p> <p>After ‘Delegated Functions’ delete the semi-colon.</p>
Clause 12.4 and 12.5	<p>Missing clause number before ‘The ICB must not terminate...’.</p>

	Insert clause number 12.5 and re-number the remaining clause numbers in Clause 12.
Clause 13.3	Missing full stop between 'Team' and 'Where appropriate'. Insert full stop.
Clause 22.3.5	Capitalised 'Receiving' which should read 'receiving'.
Clause 26.2.1	Capitalised 'Legislation' which should read 'legislation'.
Schedule 1	Missing double quotation marks on definitions of: Commissioning Team Arrangements; Confidential Information; Contracts. INSERT double quotation marks.
Schedule 1	Additional apostrophe in the definition of "Information Governance Guidance for Serious Incidents". Delete the apostrophe after the word 'Investigation'.
Schedule 1	At the definition of "Mandated Guidance" change Clause 7.5 to read Clause 7.4.
Schedule 1	At the definition of "Specialised Services Staff": i) after 'means the Staff' delete 'of' and insert 'or'. ii) after the word 'Delegated' delete the word 'Services'.
Schedule 4	Missing term.
Para.5.1	Replace '...and at NCG' with '...and at the National Commissioning Group ("NCG").

Delegated Specialised Services

In March 2024, the NHS England Board agreed to the delegation of further specialised services to ICBs.⁴ Therefore, the list of delegated specialised services in existing delegation agreements needs to be updated.

It is recommended that colleagues replace the entirety of Schedule 2 (Delegated Services) with the template schedule set out below. Where a service line has been added, it is highlighted in bold and in green.

Colleagues should:

- (a) **Delete** the entirety of Schedule 2 (Delegated Services).
- (b) **Insert** the following text:

[STARTS]

SCHEDULE 2: Delegated Services

Delegated Services

NHS England delegates to the ICB the statutory function for commissioning the Specialised Services set out in this Schedule 2 (*Delegated Services*) subject to the reservations set out in Schedule 4 (*Retained Functions*) and the provisions of any Developmental Arrangements set out in Schedule 9.

The list of Delegated Services set out in Schedule 2 of this Agreement contains two categories of service: the first is drawn from the Prescribed Specialised Services (PSS) Manual and aligns to Schedule 4 of the 2012 Standing Rules Regulations; the second is the sub-service line codes that NHS England has introduced over time to assist in the commissioning of Specialised Services. From time-to-time, NHS England will amend the list of sub-service line codes, either to repurpose, remove or add a code.

This is done to support in the management of finances, activity or for other administrative reasons; or to support transformational work that may be ongoing in the service area that requires a sub-service line code to track and manage funding and activity. The intention is that any changes will be supportive of ICBs' commissioning

⁴ NHS England, *Specialised Commissioning – update on specialised services for delegation*, March 2024, available at: <https://www.england.nhs.uk/long-read/specialised-commissioning-update-on-specialised-services-for-delegation/>

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responsibilities, and that there will be a small number of changes in the Delegated Services sub-service line codes in any one year.

All future changes to sub-service line codes relating to Delegated Services will be developed with ICBs. ICBs will be engaged and have the opportunity to provide comment on the proposed change before it is made. Changes to the sub-service line codes will be discussed at and agreed by the Delegated Commissioning Group, hosted by NHS England and attended by ICB representatives. If changes are agreed, the latest lists will be made available on the NHS England website here [[NHS England » NHS England service codes by year 2024/25](#)] and a more detailed version on the Future NHS site here [[Service Portfolio Analysis - Integrating specialised services within Integrated Care Systems - FutureNHS Collaboration Platform](#)].

The PSS Manual Lines in Schedule 2 of the Agreement, which derive from the 2012 Standing Rules Regulations, will not be altered unless there is a decision of the NHS England Board, which will necessitate wider engagement with ICBs and stakeholders.

The following Specialised Services will be delegated to the ICB on 1 April 2025:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
		29V	Complex home ventilation (adults)
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
6	Adult secure mental health services	22S(a)	Secure and specialised mental health services (adult) (medium and low) – excluding LD/ASD/WEMS/ABI/DEAF
		22S(c)	Secure and specialised mental health services (adult) (Medium and low) – ASD MHLDA PC
		22S(d)	Secure and specialised mental health services (adult) (Medium and low) – LD MHLDA PC
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology
13Z	Cardiac surgery (outpatient)		
8	Adult specialist eating disorder services	22E	Adult specialist eating disorder services MHLDA PC
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy

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PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
	Adult specialist neurosciences services (continued)	58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass(complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/ complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion
		58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
		58P	Neurosurgery LVHC local: thoracic discectomy
58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia		
58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours		
58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly		
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
		11T	Renal Transplantation
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Haematopoietic stem cell transplantation services (adults and children)
		ECP	Extracorporeal photopheresis service (adults and children)
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
32	Children and young people's inpatient mental health service	23K	Tier 4 CAMHS (general adolescent inc eating disorders) MHLDA PC
		23L	Tier 4 CAMHS (low secure) MHLDA PC
		23O	Tier 4 CAMHS (PICU) MHLDA PC
		23U	Tier 4 CAMHS (LD) MHLDA PC
		23V	Tier 4 CAMHS (ASD) MHLDA PC
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)

Appendix Two - Specialised Commissioning Delegation Agreement: Variation Proposal

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
98	Specialist secure forensic mental health services for young people	24C	FCAMHS MHLDA PC
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01X	Penile cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
19Q	Pancreatic cancer surgery (adults)		

Appendix Two - Specialised Commissioning Delegation Agreement: Variation Proposal

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		24Y	Skin cancer (adults)
		29E	Management of central airway obstruction (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children
114	Specialist haemoglobinopathy services (adults and children)	38S	Sickle cell anaemia (adults and children)
		38T	Thalassemia (adults and children)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services (adults and adolescents) MHLDA PC
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children

Appendix Two - Specialised Commissioning Delegation Agreement: Variation Proposal

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05C	Specialist augmentative and alternative communication aids (adults and children)
		05E	Specialist environmental controls (adults and children)
		05P	Prosthetics (adults and children)
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

[ENDS]

Schedule 6: further information governance, sharing and processing provisions

Amendments have been made to Schedule 6 (*further information governance, sharing and processing provisions*) to accommodate changes in the proposed approach to managing data for specialised services.

In summary, the proposed approach is that NHS England will receive and hold data relating to all specialised services and manage access to members of the Commissioning Teams in ICBs to assist in the commissioning of the Delegated Services.

To support this arrangement, Schedule 6 has been amended to include a Data Sharing Agreement and a Data Processing Agreement.

As both ICBs and NHS England are Data Controllers in this arrangement, the Data Sharing Agreement permits the sharing of information between (as an example) NHS England and the ICBs for the purposes of commissioning the Delegated Services (it can also work in the reverse).

The Data Processing Agreement will confirm that NHS England will process data in relating to the Delegated Services on behalf of the ICBs, making it available to the ICBs to assist them in fulfilling their functions.

Regional colleagues and ICBs will need to review Schedule 6 and introduce details to each agreement that covers the type of personal data being processed, and categories of data subject. These agreements can be changed over time to ensure that they cover the arrangements as they develop. For example, if new data sets or information needs to be shared or processed.

The draft schedule is provided below.

Schedule 6: consequential amendments

A small number of changes are required elsewhere in the delegation agreement due to changes in Schedule 6. These are set out in the following table.

Clause or paragraph number	Change required
18.8	Replace: <i>Further Information Governance And Sharing Provisions</i> with: <i>Further Information Governance, Sharing and Processing Provisions</i> .

29.2.8	Replace: <i>Further Information Governance And Sharing Provisions</i> with: <i>Further Information Governance, Sharing and Processing Provisions.</i>
Schedule 1, definition of: "Neet to Know"	Replace: <i>Further Information Governance And Sharing Provisions</i> with: <i>Further Information Governance, Sharing and Processing Provisions.</i>
Schedule 1, definition of: "Specified Purpose"	Replace: <i>Further Information Governance And Sharing Provisions</i> with: <i>Further Information Governance, Sharing and Processing Provisions.</i>
New definition	After the definition "Data Protection Officer" insert a new line and the following definition: <div style="display: flex; align-items: flex-start;"> <div style="margin-right: 20px;"> <p>"Data Processing Agreement"</p> </div> <div> <p>means a data processing agreement which should be in substantially the same form as a Data Processing Agreement template approved by NHS England;</p> </div> </div>

Schedule 6: replacement schedule

Delete Schedule 6 in its entirety (both Part 1 and Part 2).

And **insert** Parts 1, 2 and 3, as follows:

[STARTS]

SCHEDULE 6: Further Information Governance, Sharing and Processing Provisions

PART 1

1. Introduction

- 1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the Parties on a Need To Know basis, or where a Party acts as a Data Processor on behalf of the other Party in order to enable the Parties to exercise their functions in pursuance of this Agreement.
- 1.2. References in this Schedule (*Further Information Governance and Sharing Provisions*) to the Need to Know basis or requirement (as the context requires) should be taken to mean that each Party's Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.
- 1.3. This Schedule (including the details at Part 2 and 3 of this Schedule) and any Data Sharing Agreement and/or Data Processing Agreements entered into under this Schedule are designed to:
 - 1.3.1. provide information about the reasons why Relevant Information may need to be shared and/or processed on behalf of another Party and how this will be managed and controlled by the Parties;
 - 1.3.2. describe the purposes for which the Parties have agreed to share and/or the basis on which a Party is instructed to act as a Data Processor in relation to the Relevant Information;
 - 1.3.3. set out the lawful basis for the processing of Relevant Information and sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information;
 - 1.3.4. describe roles and structures to support the exchange of Relevant Information between the Parties;
 - 1.3.5. apply to the sharing and processing of Relevant Information relating to Specialised Services Providers and their Staff;
 - 1.3.6. apply to the sharing and processing of Relevant Information whatever the medium in which it is held and however it is transmitted;
 - 1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and processed and how this sharing and processing will be managed;
 - 1.3.8. apply to the activities of the Parties' Staff; and

- 1.3.9. describe how complaints relating to Personal Data sharing between the Parties and wider processing will be investigated and resolved, and how the information sharing and processing will be monitored and reviewed.

2. Purpose

- 2.1. The Specified Purpose of the data sharing and associated processing is to facilitate the exercise of the Delegated Functions and NHS England's Reserved Functions.
- 2.2. Each Party must ensure that they have in place appropriate data sharing or data processing arrangements to enable data to be received from any third party organisations from which the Parties must obtain data in order to achieve the Specified Purpose.
- 2.3. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement or Data Processing Agreement that complies with all relevant legislation and Guidance.

3. Benefits of information sharing

- 3.1. The benefits of sharing information are the achievement of the Specified Purpose, with benefits for service users and other stakeholders in terms of the improved delivery of the Delegated Services.

4. Lawful basis for sharing

- 4.1. The Parties shall comply with all relevant Data Protection Legislation requirements and Good Practice in relation to the processing of Relevant Information shared further to this Agreement.
- 4.2. The Parties shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.
- 4.3. Further details regarding the Relevant Information to be shared shall be set out in a Data Sharing Agreement and/or Data Processing Agreement.

5. Restrictions on use of the Shared Information

- 5.1. Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.
- 5.2. Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Data Protection Legislation requirements, and the Parties' Staff should only have access to Personal Data on a justifiable Need to Know basis.
- 5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreement and/or Data Processing Agreement should be taken to permit unrestricted access to data held by any of the Parties.
- 5.4. Neither Party shall subcontract any processing of the Relevant Information without the prior consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the subcontractor which imposes the same obligations as are imposed on that Party under this Agreement, and shall remain liable for the performance of the subcontractor's obligations.
- 5.5. The Parties shall not cause or allow Data Relevant Information to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.
- 5.6. Any particular restrictions on use of certain Relevant Information should be included in a Data Sharing Agreement and/or Data Processing Agreement.

6. Ensuring fairness to the Data Subject

- 6.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the Parties will take the following measures as reasonably required:
 - 6.1.1. amendment of internal guidance to improve awareness and understanding among Staff;

- 6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;
 - 6.1.3. ensuring that information and communications relating to the processing of data is clear and easily accessible; and
 - 6.1.4. giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.
- 6.2. Each Party shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.
- 6.3. The Parties shall reasonably co-operate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.
- 6.4. Further provision in relation to specific data flows may be included in a ~~Personal~~ Data Sharing Agreement and/or Data Processing Agreement between the Parties.

7. Governance: Staff

- 7.1. The Parties must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.
- 7.2. The Parties agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Parties' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018), the employing Parties must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.
- 7.3. The Parties shall ensure that all Staff required to access Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data. The Parties shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure

provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

- 7.4. Each Party shall provide evidence (further to any reasonable request) that all Staff that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.
- 7.5. The Parties shall ensure that:
 - 7.5.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information;
 - 7.5.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and
 - 7.5.3. specific limitations on the Staff who may have access to the Relevant Information are set out in any Data Sharing Agreement and/or Data Processing Agreement entered into in accordance with this Schedule.

8. Governance: Protection of Personal Data

- 8.1. At all times, the Parties shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.
- 8.2. Wherever possible (in descending order of preference), only anonymised information, or, strongly or weakly pseudonymised information will be shared and processed by the Parties. The Parties shall co-operate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.
- 8.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis.
- 8.4. If any Party becomes aware of:
 - 8.4.1. any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

- 8.4.2. any security vulnerability or breach in respect of the Relevant Information,
- it shall promptly, within 48 hours, notify the other Parties. The Parties shall fully co-operate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.
- 8.5. In processing any Relevant Information further to this Agreement, the Parties shall process the Personal Data and Special Category Personal Data only:
- 8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information including any instructions set out in a Data Processing Agreement entered into under this Schedule, unless required by law (in which case, the processor shall inform the relevant Data Controller of that legal requirement before processing, unless that law prohibits such information on important grounds of public interest);
- 8.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body; and
- 8.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.
- 8.6. The Parties shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protect Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:
- 8.6.1. take account of the nature, scope, context and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and

- 8.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data, and having the nature of the Personal Data and Special Category Personal Data which is to be protected.
- 8.7. In particular, each Party shall:
- 8.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;
 - 8.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;
 - 8.7.3. obtain prior written consent from the originating Party in order to transfer the Relevant Information to any third party;
 - 8.7.4. permit any other party or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Party to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and
 - 8.7.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.
- 8.8. The Parties shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement and/or Data Processing Agreement entered into in accordance with this Schedule.
- 8.9. The Parties shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.
- 8.10. The Parties' Single Points of Contact set out in paragraph **Error! Reference source not found.** will be the persons who, in the first instance, will have oversight of third party security measures.

9. Governance: Transmission of Information between the Parties

- 9.1. This paragraph supplements paragraph 8 of this Schedule.
- 9.2. Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.
- 9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record and/or data is identified.
- 9.4. Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement and/or Data Processing Agreement entered into in accordance with this Schedule.
- 9.5. Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.
- 9.6. The Parties' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

10. Governance: Quality of Information

- 10.1. The Parties will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11. Governance: Retention and Disposal of Shared Information

- 11.1. A non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.

- 11.2. Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.
- 11.3. If a Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in accordance with this Schedule, it shall notify the other Parties in writing of that retention, giving details of the documents or materials that it must retain.
- 11.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all Good Practice including the Records Management NHS Code of Practice, as updated or amended from time to time.
- 11.5. The Parties shall set out any special retention periods in a Data Sharing Agreement where appropriate.
- 11.6. The Parties shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.
- 11.7. Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.
- 11.8. Electronic records will be considered for deletion once the relevant retention period has ended.
- 11.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12. Governance: Complaints and Access to Personal Data

- 12.1. The Parties shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them (“Subject Access Requests”), as well as any other exercise of a Data Subject’s rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.

- 12.2. Complaints about processing shall be reported to the Single Points of Contact and the ICB. Complaints about information sharing shall be routed through each Parties' own complaints procedure unless otherwise provided for in the Agreement or determined by the ICB. Where the complaint relates to processing undertaken by a Party acting as a Data Processor on behalf of the other Party, complaints shall be routed through the relevant Data Controller's own complaints procedure unless otherwise provided for in the Agreement.
- 12.3. The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.
- 12.4. Basic details of the Agreement shall be included in the appropriate log under each Party's publication scheme.

13. Governance: Single Points of Contact

- 13.1. The Parties each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14. Monitoring and review

- 14.1. The Parties shall monitor and review on an ongoing basis the sharing and wider processing of Relevant Information to ensure compliance with Data Protection Legislation and Best Practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement and/or Data Processing Agreement.

SCHEDULE 6: Further Information Governance, Sharing and Processing Provisions

PART 2

Data Sharing Agreement

Description	Details
<p>Subject matter of the processing</p>	<p>Due to the complexities of Specialised Services and the distinctions between Delegated Functions and Reserved Functions, both the ICB Commissioning Teams (employed by the Host ICB) delivering Delegated Functions and the NHS England teams delivering Reserved Functions will need access to Relevant Information, which contains Personal Data.</p> <p>As set out in Schedule 6, Part 1, Paragraph 2.1, the Specified Purpose for sharing data is: ‘...to facilitate the exercise of the Delegated Functions and NHS England’s Reserved Functions.’ In order to achieve this purpose in the most effective, efficient and cost effective manner, the data will be hosted by NHS England in a collaborative working space which ICBs will have access to.</p> <p>NHS England will be responsible for ensuring that Commissioning Team staff have sufficient and appropriate access to Relevant Information to enable those staff to fulfil their commissioning functions in respect of the Delegated Services, including those described in Schedule 3 (Delegated Functions) to this agreement.</p> <p>In addition, NHS England may process the data for the following purposes:</p> <ul style="list-style-type: none"> • development, oversight, and the quality improvement of Specialised Commissioning Functions; • undertaking work to evaluate the effectiveness of innovation and changes in delivery models and advising other bodies and organisations about these functions; • arranging the provision of services to support commissioning activities, to enable reporting and evaluations;

	<ul style="list-style-type: none"> • undertaking analysis, audits, and inspections to assess and assure the quality of Specialised Commissioning Functions; • supporting healthcare organisations to interpret population health data and evidence, and to undertake reviews of the likely effectiveness and cost-effectiveness of a range of interventions; • development a of strategies on population health outcomes and to identify gaps or deficiencies in current care and to produce recommendations for improvements, including in relation to specific pathways of care; • using and supporting health organisations to use health economic tools to support decision-making and interpreting data about the surveillance or assessment of a population’s health to improve health outcomes and reduce health inequalities; • the development of population health policies and strategies, and their implementation
Duration of the processing	Unless otherwise specified in this Data Sharing Agreement, the processing shall commence on the Effective Date of Delegation and, as per paragraph 11.1 of this Schedule, shall continue until the need to use it has passed or, if later, upon the termination of this Agreement.
Nature and purpose of the processing	<p>Personal Data is shared between the in relation to the delivery of the Delegated Functions. Such processing should ensure continued:</p> <ul style="list-style-type: none"> • Provision of live services and associated reporting; • Quality improvement and assurance of services; • Dissemination of data for health and research purposes.
Type of Personal Data being Processed	<i>[An updated Data Protection Impact Assessment and Joint Control Agreement between the three NW ICBs and NHS England will be updated and shared in Q1 2025/26.]</i>
Categories of Data Subject	<i>[An updated Data Protection Impact Assessment and Joint Control Agreement between the three NW ICBs and NHS England will be updated and shared Q1 2025/26.]</i>

SCHEDULE 6: Further Information Governance, Sharing and Processing Provisions

PART 3

Data Processing Agreement

Description	Details
Identity of the Controller and Processor	The ICB is the Data Controller and NHS England is the Data Processor.
Subject matter of the processing	<p>Both the ICB Commissioning Teams (employed by the Host ICB) delivering Delegated Functions and the NHS England teams delivering Reserved Functions will need access to Relevant Information. In order to achieve this purpose in the most effective, efficient and cost effective manner, the data will be hosted by NHS England in a collaborative working space which ICBs will have access to.</p> <p>Consequently, NHS England will act as a Data Processor on behalf of the ICB in relation to the Relevant Information required to commission the Delegated Services and fulfil the Delegated Functions.</p>
Duration of the processing	Unless otherwise specified in this Data Processing Agreement the processing shall commence on the Effective Date of Delegation and, as per paragraph 11.1 of this Schedule, shall continue until the need to use it has passed or, if later, upon the termination of this Agreement.
Plan for return and destruction of the data once the processing is complete	As set out in paragraph 11.1 of this Schedule
Nature and purpose of the processing	<p>This Data Processing Agreement considers processing of any data by NHS England on behalf of the ICB Commissioning Teams in relation to the delivery of the Delegated Functions. Such processing should ensure continued:</p> <ul style="list-style-type: none"> • Provision of live services and associated reporting; • Quality improvement and assurance of services; • Dissemination of data for health and research purposes.

Type of Personal Data being Processed	<i>Data will continue to be processed as set out in the Data Services for Commissioners Regional Office (DSCRO) arrangements described in the Health and Social Care Act 2012. There is no change to the type of personal information being processed.</i>
Categories of Data Subject	<i>Data will continue to be processed as set out in the Data Services for Commissioners Regional Office (DSCRO) arrangements described in the Health and Social Care Act 2012. There is no change to the type of categories of data subject information being processed.</i>

[ENDS]

DRAFT

Appendix Three

Covid uptake in trusts (published data from NHS England) as at 31st Dec 2024

Organisation name ³	Number of frontline healthcare workers	Number of frontline healthcare workers who have had an autumn covid vaccination	Percentage of frontline healthcare workers who have had an autumn covid vaccination
Cheshire and Merseyside	71,136	14,413	20.26%
EAST CHESHIRE NHS TRUST	1,741	523	30.00%
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	3,031	858	28.30%
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	4,244	1,192	28.10%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	3,901	1,092	28.00%
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	987	229	23.20%
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	4,687	996	21.30%
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	11,142	2,288	20.50%
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	20,256	3,859	19.10%
MERSEY CARE NHS FOUNDATION TRUST	9,092	1,712	18.80%
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	3,251	574	17.70%
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1,363	215	15.80%
WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	1,106	166	15.00%
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	2,972	375	12.60%
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	1,328	135	10.20%
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	1,076	108	10.00%
THE WALTON CENTRE NHS FOUNDATION TRUST	959	91	9.50%
NORTH WEST AMBULANCE SERVICE*	4,141	253	6.10%

* NWAS not included in the overall C&M uptake percentage as covers a wider geographic area than C&M

Flu vaccination uptake in Trust (published data from NHS England) January 2025

Organisation name ³	Number of frontline healthcare workers	Number of frontline healthcare workers who have had an autumn flu vaccination	Percentage of frontline healthcare workers who have had an autumn flu vaccination
NORTH WEST	71,136	27,736	38.99%
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST**	1,076	570	53.00%
EAST CHESHIRE NHS TRUST	1,741	901	51.80%
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	4,687	2,262	48.30%
THE WALTON CENTRE NHS FOUNDATION TRUST**	959	452	47.10%
WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	1,106	512	46.30%
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST**	3,251	1,465	45.10%
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	4,244	1,905	44.90%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	3,901	1,728	44.30%
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	2,972	1,263	42.50%
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	3,031	1,271	41.90%
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	20,256	7,393	36.50%
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	987	360	36.50%
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	1,328	474	35.70%
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	11,142	3,876	34.80%
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1,363	441	32.40%
MERSEY CARE NHS FOUNDATION TRUST	9,092	2,863	31.50%
NORTH WEST AMBULANCE SERVICE	4,141	1,503	36.30%

Data source - [Autumn-Winter-2024-25-Monthly-COVID-Flu-vaccinations-16-January-2025.xlsx](#)

*NWAS not included in the overall C&M uptake percentage as covers a wider geographic area than C&M

**Bridgewater, Warrington and the Walton centre did not deliver the covid programme. Staff in these trusts were signposted to local services.

Meeting of the Board of NHS Cheshire and Merseyside

30 January 2025

Director of Nursing Report

Agenda Item No: ICB/01/25/06

Responsible Director: Chris Douglas
Executive Director of Nursing and Care



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Director of Nursing Report (January 2025)

1. Purpose of the Report

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

2. Executive Summary

- 2.1 An update is provided in relation to:
- Patient Safety Strategic Development
 - Special Educational Needs & Disabilities (SEND) Co-Production Charter
 - Maternity Services at East Cheshire Foundation Trust

3. Ask of the Board & Recommendations

- 3.1 The Board is asked to:
- note the contents of the report for assurance purposes.

4. Reasons for Recommendations

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

5. Focus Areas

- 5.1 **Patient Safety Strategic Development.** An integral part of the ICBs role as a strategic commissioner is to keep those who use the services it commissions safe, protecting them from avoidable harm. The World Health Organisation (WHO) estimates that 50% of harm in health care is avoidable, and that avoidable harm is one of the biggest causes of mortality in health services, alongside an increase in subsequent morbidity and psychological harm for both the population we serve, and those delivering health and care services.
- 5.2 According to the Organisation for Economic Cooperation & Development (OECD), 13 -15% of health spend relates to responding to avoidable harm, therefore an extrapolation of that estimate, based upon a C&M ICB budget of circa £7bn, equates to a financial impact of approximately £1bn. Therefore, alongside the ethical imperative, there is also a financial incentive to reduce avoidable harm for our population.

- 5.3 The unique ability of the ICB to act as system convenor, means that safety can be managed as an opportunity for system learning, not as a performance matter. Safety must be central to the governance and oversight of the ICS. It is an opportunity to use systems thinking and embed an improvement approach, reinforcing the relationship between safety and improvement.
- 5.4 Safety must be viewed as everyone’s responsibility, as a failure to keep people safe in one part of the system has a detrimental impact across all aspects of care delivery. In defining a system-based model for safety, there is much by way of evidence of the essential ingredients, as per the model suggested by AQUA (2023)¹ in Diagram 1 below.



Diagram 1

- 5.5 The ICB has adopted the AQUA framework in developing its strategic approach to system safety.
- 5.6 **Culture** is viewed as the most important step in developing system safety. NHS England defines a safety culture as one where:

‘...the environment is collaboratively crafted, created, and nurtured so that everybody (individual staff, teams, patients, service users, families, and carers) can flourish to ensure brilliant, safe care by: Continuous learning and improvement of safety risks...’

¹ AQUA (2023) What Should Safety Look Like at System Level?

- 5.7 Having a just and learning culture is centred on the desire to create an environment where staff feel supported and empowered to learn when things do not go as expected, rather than feeling blamed. This is a culture that instinctively asks in the case of an adverse event: “what was responsible, not who is responsible.” This approach should not be mistaken for an uncritically tolerant culture, as that would be as inexcusable as a blame culture.
- 5.8 The widely reported mistakes in some NHS organisations were not helped by reluctance amongst employees to report those mistakes. That reluctance came from concern about what the personal consequences might be.
- 5.9 A change in culture will require a focus on continuous improvement using an iterative cycle of change and improvement. AQUA describes using existing tools in a consistent and collaborative way across the system. Many of our large NHS providers are leading the way in culture change, developing training and support to our workforce, as an ICB, in our role as system convenor, we will work at scale to strengthen a safety culture across all commissioned services.
- 5.10 **Leadership** for system safety requires leaders at all levels in a system to demonstrate the correct behaviours to lead a safety culture across their system. Leadership in the safety arena should take the form of ‘problem sensing’ (actively seek out weaknesses, multiple sources of data, and softer intelligence from active listening to patients and staff and informal visits to clinical areas) and comfort seeking (a focus on external impression management and seeking reassurance that all is well, using a limited range of data, and a preoccupation with demonstrating compliance). The ICB will work with system partners to develop leaders at all levels, so that they have the skills and confidence to encourage and support a just and learning culture.
- 5.11 **Systematic Management** of safety requires a governance framework that ensures a clear line of sight to identify risks to patient safety at the earliest opportunity to negate or reduce the impact of avoidable harm. The ICB has continued to develop its approach to quality and safety governance in this vein, to ensure identification and action occurs closest to the point of care delivery. The ICB approach aligns to the framework set out by the National Quality Board (NQB) illustrated in Diagram 2.

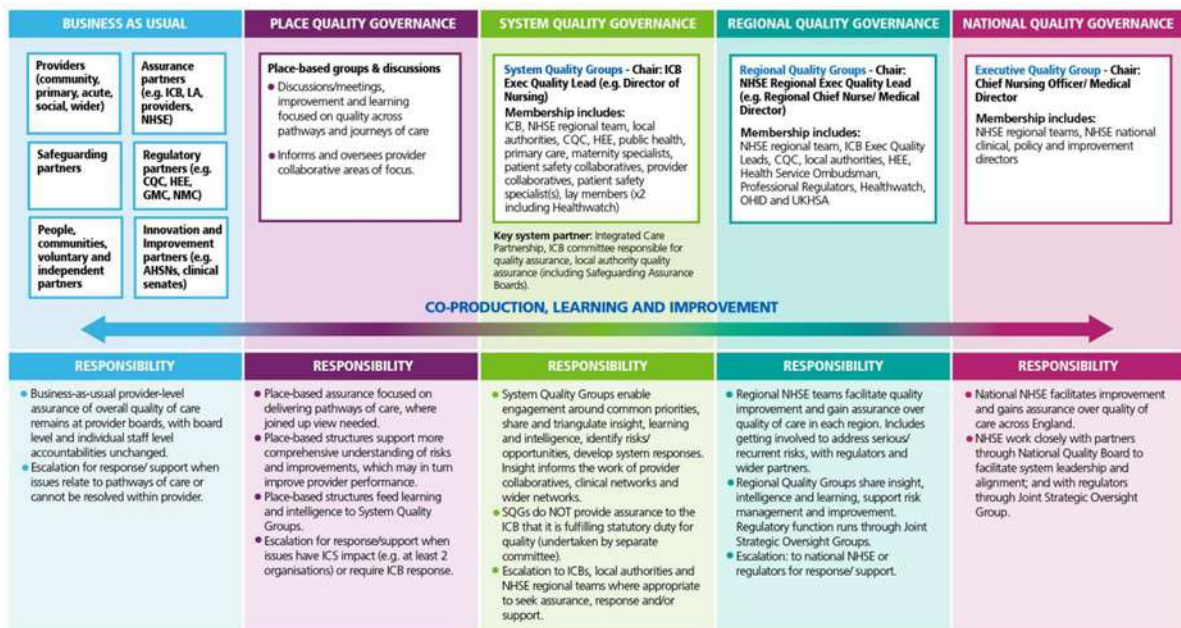


Diagram 2.

5.12 New **models of care** using resources across the whole system are needed, and ICBs are ideally placed to affect that change. Safety must be at the core of these new models of care, not added as an afterthought. Current models of care are based on legacy approaches and professional perspectives, rather than what works for patients today. Greater system safety will be achieved through the ICB commissioning new models of care aligned to the Darzi Report². Therefore, in designing, developing and reviewing services, NHS Cheshire & Merseyside have agreed a set of quality statements laid out below, with safety being central, in that the ICB will commission care in such a way that is:

- **Safe:** Avoid harm and safeguard those at risk from care that is intended to help them, learning when things go wrong and continually improving.
- **Effective & Sustainable:** Commission services based on best practice to those who benefit from them, delivered by staff who are confident and competent to provide them.
- **Person-centred:** Commission care that is informed by personal experiences and developed jointly with service users and/or their carers.
- **Timely:** Reduce waits and delays for those who receive, and those who give care.
- **Efficient:** Avoid waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable:** Commission care that does not vary in quality because of personal characteristics or place of residence. Activities will be designed to improve the health and wellbeing of the whole population through effective prevention, addressing the wider determinants of health.

² Independent Investigation of the National Health Service in England

- 5.13 The ICB commissioning strategy and operating model will ensure that care is delivered closer to home, with a focus on prevention and with greater utilisation of technology, all of which will support the reduction/elimination of avoidable harm.
- 5.14 **Innovation** and technology offer a rich source of improvement, which must be better harnessed to support system safety. Both access to information and its analysis will support us in early identification and action in those areas where we see avoidable harm occurring and allow us to review and redesign services in a way that minimises risks to safety. The ICB is seen as a system leader in its approach to digital developments and more can be achieved in using the resource through the lens of patient safety, particularly in allowing us to pinpoint those groups where we see disproportionate levels of avoidable harm as a result of personal characteristics or place of residence.
- 5.15 Seeing system safety through the stories and accounts of those with **lived experience** is essential if the ICB is to commission care that is responsive to need. A familiar theme in inquiries into care failings has been patients' concerns not being heard or acted upon. Through the development of its commissioning strategy and approach to quality governance, the ICB is seeking to strengthen the input of those who use commissioned services, an example of this can be seen later in this report through the development of the SEND Co-Production Charter.
- 5.16 The ICB will continue to develop its strategic approach to effective system safety and seek assurance on the strategic direction through Quality & Performance Committee.
- 5.17 **The SEND Co-Production Charter.** Co-production is an underpinning principle of the SEND Code of Practice (2015)³. Defined as *'The way which ensures that children, young people (CYP) and parents feel they have participated fully in a process and have a sense of co-ownership.'* This is often referred to as co-production...it is a useful way to engage families. Defined by the Council for Disabled Children as one of the underlying principles of quality improvement in SEND, they recommend that 'Senior leaders need to understand and value co-production at an individual and system level to create meaningful change.'⁴
- 5.18 An ICB Parent Carer Forum Leads meeting was established in October 2023. Chaired by the ICB Director of Nursing and Care, as the ICB Executive Lead for SEND, the group meets bi-monthly. This meeting provides a platform for parents and carers from the nine Places across Cheshire and Merseyside to communicate directly with the Executive Lead on a regular basis. The meeting ensures an awareness of current issues impacting on CYP with SEND and their families and provides a regular opportunity to share lived experiences of SEND across Cheshire and Merseyside.

³ [SEND code of practice: 0 to 25 years - GOV.UK](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/681212/SEND-code-of-practice-0-to-25-years-2015.pdf)

⁴ <https://councilfordisabledchildren.org.uk/resources/all-resources/filter/inclusion-send/send-quality-improvement-qi-framework>

- 5.19 A priority task for the group was to work together to co-design and co-develop a Co-production Charter (**Appendix One**). It was the parent/carers collective decision that this would replace a traditional Terms of Reference or Memorandum of Understanding for the meeting. Instead, the charter is intended to be used at the start of each meeting with the 'We will' section acting as a benchmark for co-production in the meeting. All group members are encouraged to hold each other to account to the seven agreed statements. It is anticipated that this approach of checking and challenging each other will enable the group to quickly embed a culture of co-production. The concept of content of the SEND Co-Production Charter could be applied across all commissioned services.
- 5.20 **Maternity Services at East Cheshire Foundation Trust (ECFT).** In February 2016, NHS England published the policy document Better Births, which set out a vision of how NHS maternity services in England should be improved. The Local Maternity Systems were formalised in 2017 to implement those changes.
- 5.21 Before 2017 ECFT (Macclesfield) was a member of the C&M Women's and Children's Vanguard programme and an active member of the GMEC Maternity Strategic Clinical Network (SCN) due to patient flows across the system. At the time that the LMNS's were established, conversations took place with ECFT and the then GM Health and Social Care Partnership Executives and it was agreed that ECFT would face towards GM LMNS, creating Greater Manchester and Eastern Cheshire LMNS.
- 5.22 As part of GMEC LMNS, East Cheshire maternity data flows into the GMEC maternity dashboard to support quality improvement. When ICB's were established the role of LMNS moved from one of transformation and quality improvement to a greater focus on safety and assurance. GMEC LMNS has continued to undertake safety reviews and assurance reviews for ECFT maternity services with Cheshire and Mersey LMNS and ICB colleagues joining these planned visits in a coordinated approach.
- 5.23 The accountability for the assurance of maternity services, commissioning, and contracting sits with the ICB; for East Cheshire Trust this is Cheshire and Merseyside ICB. During 2024/25 the Trust has continued to actively participate in GMEC quality improvement work and receive support to adhere to national assurance requirements. However, as the assurance requirements of the ICBs increase, this disconnect in responsibility and accountability is creating risks of duplication and omission in support and oversight.
- 5.24 With the development of respective Oversight and Assurance Frameworks within each ICB, including Trust MIS sign off by the ICB CEO, there is now an urgency to consider where ECFT services align for quality assurance and improvement.
- 5.25 Assurance for maternity services sits with Cheshire and Merseyside ICB and therefore, the C&M LMNS require greater oversight of the quality of services to be able to fulfil assurance requirements. GM LMNS are unable to support ECFT in targeted quality improvement areas such as pelvic health, continuity of carer

and maternity and neonatal voices partnership (MNVP) model leading to inequity in approach and support across GMEC maternity providers and potential disconnect between commissioner and provider.

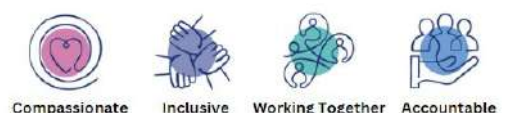
- 5.26 Following ongoing meetings between the respective ICBs it is recommended that ECFT services transition in Q1 25/26 to Cheshire and Mersey LMNS for oversight of assurance and quality improvement processes, including assurance of CNST evidence (MIS Year 7) and the 3-year plan. GM LMNS will cease active evaluation of evidence from East Cheshire for these processes and will cease including East Cheshire maternity data reporting. Cheshire and Mersey ICB will provide these services and support and retain full maternity SDF capacity resource to support assurance and QI. A meeting has been arranged with the Trust Executives in January 2025 (Q4 24/25) to discuss the outcome and recommendations from this committee
- 5.27 The recommendation for transfer of ECFT maternity and neonatal services was made to the January 2025 Quality & Performance Committee, with a request made by the committee for a full risk assessment to the February 2025 meeting, when levels of assurance can be agreed, with subsequent final recommendation made to the ICB in March 2025.

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

- 6.1 The current work plan and programmes complements the CQC/ ICS Quality Statements and in particular:
 - How we work as partners for the benefit of our population
 - Population Health
 - Learning Culture.

7. Link to meeting CQC ICS Themes and Quality Statements

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



QS9	How staff, teams and services work together . We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services
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8. Risks

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

9. Next Steps and Responsible Person to take forward.

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

10. Officer contact details for more information

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

Cheshire and Merseyside Parent Carer Forum Cluster Group SEND Co-production Charter

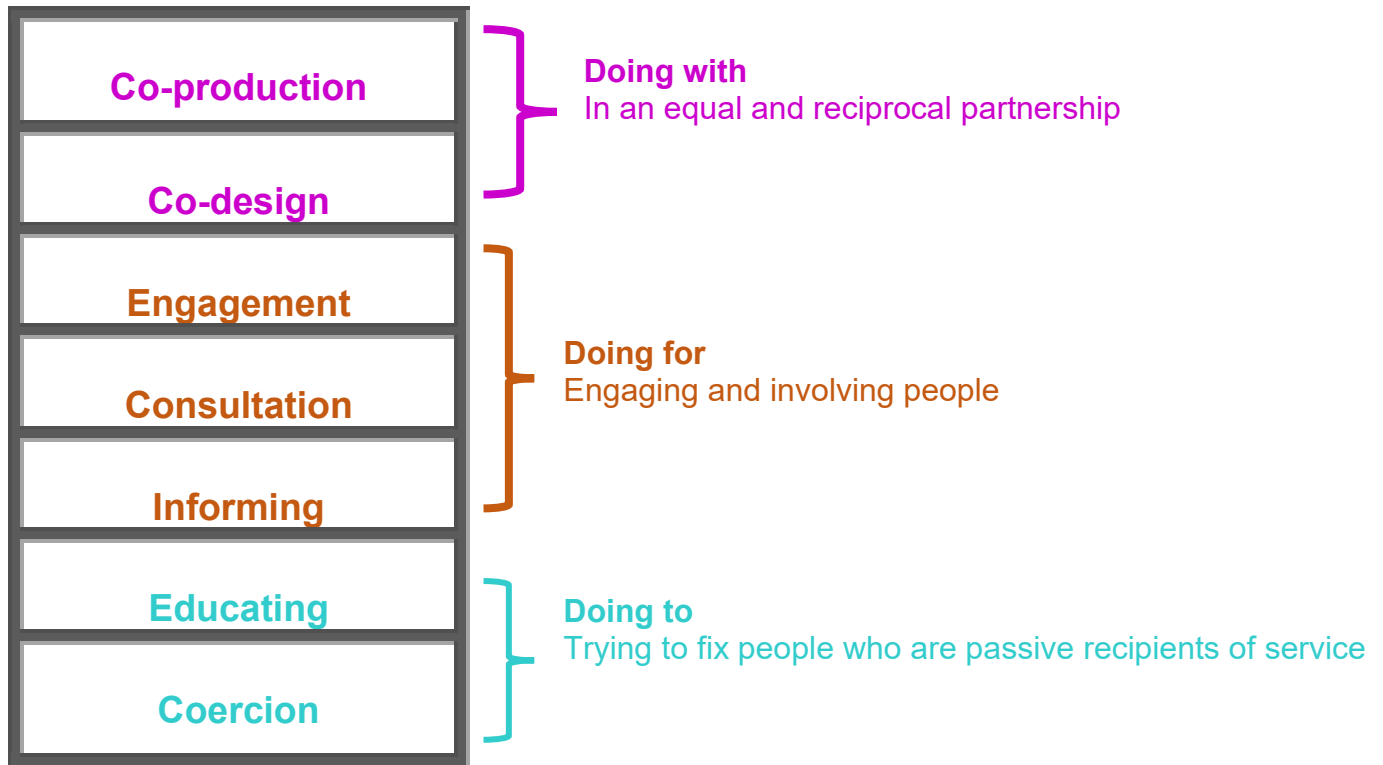
Our overall aim is to make sure that Special Educational Needs and Disabilities (SEND) services across Cheshire and Merseyside meet the needs of children, young people, and their families.

We will deliver better outcomes for families living with SEND by listening to those with lived experience.

We will create a culture of participation and co-production.



We take a 'do with' approach to co-production



Why Co-production?

Co-production acknowledges that people with 'lived experience' of a condition are often best placed to advise on what support and services will make a positive difference to their lives. Done well, co-production helps to ground discussions, and maintain a person-centred perspective.

The main advantage of co-production is the improvement in the quality of public services being more in line with user needs, as well as actively involving those who use these services.

Good co-production promotes empowerment, self-worth, and allows new ways of working to be identified, giving practitioners and services a more user focused approach. People within their own communities understand better than anyone else what is needed in their area. Co-production brings those people and stakeholders together to create and deliver better services. It can support outcomes like employability and wellbeing, social interaction and peer support.

To conclude, co-production isn't meant to be easy, it should be challenging. The public become, not the passive recipients of services, but the active agents of their own life for better outcomes. It takes courage and an investment of time and resources to genuinely build transformational co-production.



We will:

Hold each other to account, but do so with respect and kindness.

Ensure everyone is aware of our approach to co-production and provide clear evidence of it taking place across the partnership.

Engage in creative ways to ensure all voices are heard.

Ensure that everyone involved has enough information, and any support that is necessary, to take part in co-production and decision making.

Use plain language and give suggested ideas equal weighting.

Be honest, do what we say we will and explain why if things are not possible.

Ensure that everyone involved is trained in the principles and values of co-production and have the time, resources and flexibility to work together effectively.

On behalf of NHS Cheshire and Merseyside ICB:	On behalf of CM SEND Parent Carer Forum Cluster Group:
Signed: 	Signed:
Name: Christine Douglas	Name: Sue Swinchin
Role: Director of Nursing & Care	Role: Co-chair Sefton PCF
Date: 14 th January 2025	Date: 13 th January 2025
<i>This Charter will be reviewed in January 2026</i>	

When working together, partners in Cheshire and Merseyside are encouraged to continually reflect on whether they are truly co-producing together.

Meeting of the Board

NHS Cheshire and Merseyside

30 January 2024

Cheshire and Merseyside Integrated Care System Finance Report Month 8 (2024/25)

Agenda Item No: ICB/01/25/07

Responsible Director: Mark Bakewell
Executive Director of Finance



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Cheshire and Merseyside System Finance Report Month 8

1. Purpose of the Report

- 1.1 This report provides an update to the Committee of NHS Cheshire and Merseyside on the financial performance of the Cheshire and Merseyside ICS (“the ICS”) at Month 8 2024/25, in terms of relative position against its financial plan, and alongside other measures of financial and operational performance (e.g. efficiency, productivity and workforce).
- 1.2 The Committee is asked to note the contents of this report in respect of the Month 8 ICS financial position for both revenue and capital allocations within the 2024/25 financial year. There is considerable risk in the delivery of both Provider and ICB financial positions and corrective action is required to secure efficiency savings to support delivery of the overall system financial plan.

2. Executive Summary

- 2.1 Regular financial performance reports are provided to the Finance, Investment and Resources Committee of the ICB who undertake detailed review and challenge on behalf of the Board.
- 2.2 On 2nd May 2024 the System ‘ICS’ plan submitted was a combined £215.8m deficit, consisting of £40.9m surplus on the commissioning side (ICB) partially offsetting an aggregate NHS Provider deficit position of £256.7m. This plan was not approved by NHSE, and subsequently a revised plan of £150m deficit (£62.3m surplus for the ICB and £212.3m for providers) was agreed and submitted on 12th June 2024.
- 2.3 NHS England issued an allocation of £150m ‘revenue deficit support’ to the ICB in month 6 to cover the deficit to allow the financial system plan to be modified to a balanced breakeven position. The funding was distributed to providers and in turn collective provider plans have improved. The revenue deficit support is deemed repayable to NHSE, phased from 2026/27.
- 2.4 As of 30th November 2024 (Month 8), the ICS system is reporting a YTD deficit of **£129.5m** against a planned YTD deficit of **£62.1m** resulting in an adverse YTD variance of **£67.4m** (1.3% of allocation).
- 2.5 The ICS financial position as reported to NHS England at Month 8 is set out in **Table 1** below. NB: NHSE require the forecast to remain on plan at Month 8, this forecast carries a significant amount of risk with risk adjusted forecast value of **£72.6m** representing a level of unidentified migrations as at Month 8.



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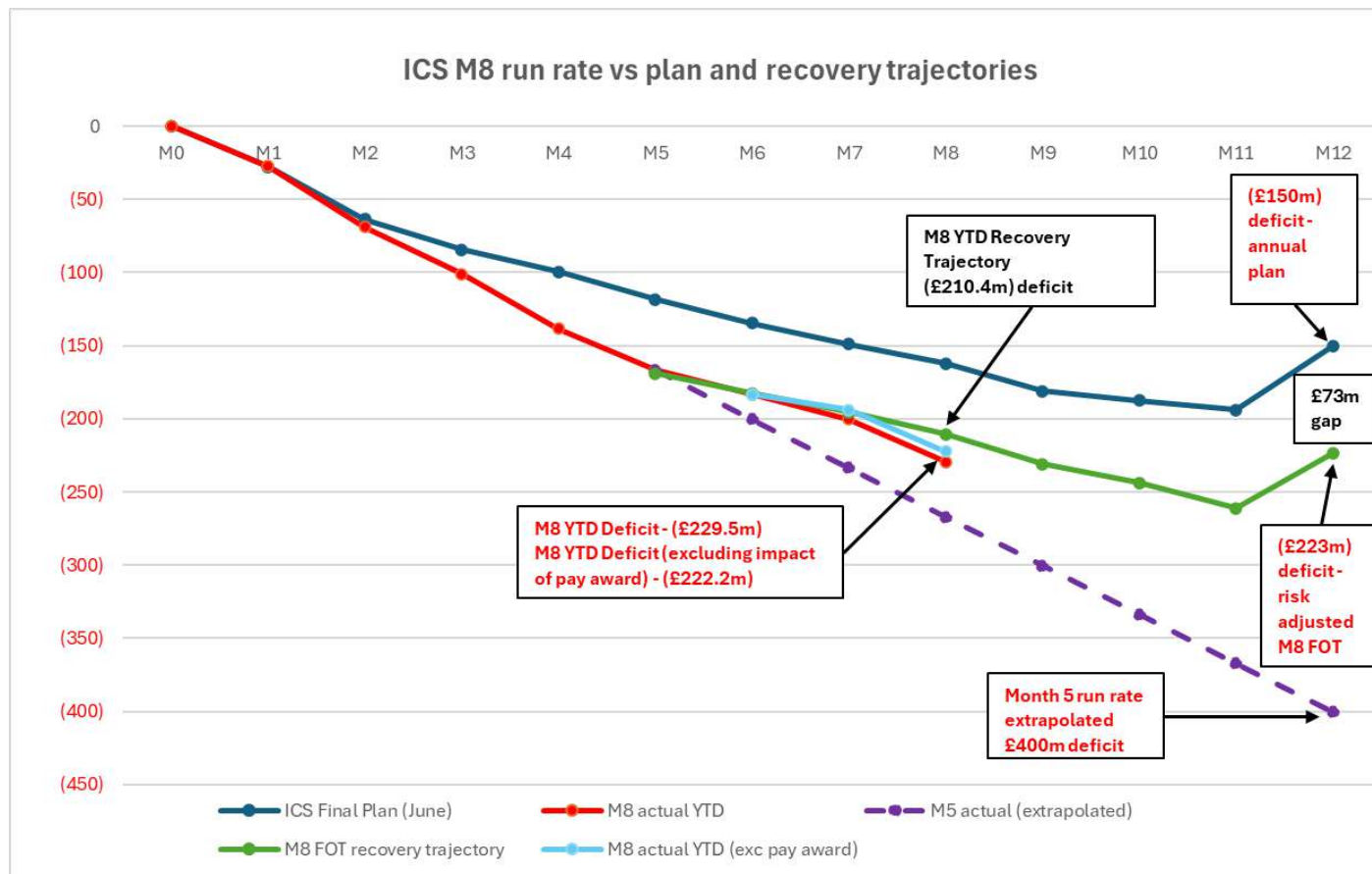
Accountable

2.6 Table 1 – Financial Performance Month 8 YTD and FOT

	M8 YTD				24/25 FY Plan				24/25 Risk Adjusted FOT (FY)		
	Plan £m	Actual £m	Variance £m	%	Plan £m	FOT £m	Variance £m	%	FOT £m	Variance to plan £m	%
ICB	41.5	0.8	(40.7)	-0.8%	62.3	62.3	0.0	0.0%	30.4	(32.0)	-0.4%
Total Providers	(103.7)	(130.3)	(26.7)	0.6%	(62.3)	(62.2)	0.0	0.0%	(102.9)	(40.6)	-0.6%
Total System	(62.1)	(129.5)	(67.4)	-1.3%	0.0	0.0	0.0	0.0%	(72.6)	(72.6)	-1.0%
Total Providers (exc. £150m rev support)	(203.7)	(230.3)	(26.7)	0.6%	(212.3)	(212.2)	0.0	0.0%	(252.9)	(40.6)	-0.6%
Total System (exc. £150m rev support)	(162.1)	(229.5)	(67.4)	-1.3%	(150.0)	(150.0)	0.0	0.0%	(222.6)	(72.6)	-1.0%

2.7 Chart 1 below shows the profile of the ICS I&E plan and recent revised recovery trajectories against the actual M7 YTD run rate. It excludes the £150m revenue deficit support to evidence the comparable run rate position month to month (actual and forecast).

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



2.8 The Month 8 risk adjusted forecast value of £72.6m is an improvement of £0.9m compared to Month 7 risk adjusted forecast of £73.5m. This has been driven by a reassessment of the reduced impact from the recently notified pay award now by two providers now actual payments have been made. The reported level of ICB unmitigated risk has remained unchanged during the month.

2.9 A summary of those organisations currently reporting a risk adjusted FOT adverse to plan is set out in **Table 2**, and how this compares to the previous risk adjustment position at Month 6 and Month 7.

Table 2 – Risk Adjusted FOT vs Plan as at Month 8

Org	FY Plan 24/25 £m	Month 6		Month 7		Month 8		M6 to M8 Movement on Risk Adjusted FOT Position £m	M6 to M8 movement explained by:			TOTAL £m
		M6 Risk Adjusted FOT Position £m	M6 Risk Adjusted Variance vs Plan £m	M7 Risk Adjusted FOT Position £m	M7 Risk Adjusted Variance vs Plan £m	M8 Risk Adjusted FOT Position £m	M8 Risk Adjusted Variance vs Plan £m		Adverse movement linked to PAY AWARD £m	PAY AWARD impact absorbed in position £m	Other changes £m	
Alder Hey Children's	3.4	4.4	1.0	3.4	0.0	3.4	0.0	(1.0)	(1.0)	0.0	0.0	(1.0)
Bridgewater Community	2.1	0.2	(2.0)	0.1	(2.1)	0.1	(2.1)	(0.1)	0.0	0.0	(0.1)	(0.1)
Cheshire & Wirral Partnership	1.5	1.5	0.0	1.5	0.0	1.5	0.0	0.0	0.0	0.0	0.0	0.0
Countess of Chester Hospitals	(23.6)	(23.5)	0.0	(25.8)	(2.2)	(25.4)	(1.8)	(1.8)	(1.8)	0.0	0.0	(1.8)
East Cheshire Trust	(14.4)	(14.3)	0.1	(14.3)	0.1	(14.3)	0.1	0.0	0.0	(0.8)	0.8	0.0
Liverpool Heart & Chest	14.1	14.1	0.0	14.1	0.0	14.1	0.0	0.0	0.0	0.0	0.0	0.0
Liverpool University Hospitals	(80.5)	(95.3)	(14.8)	(98.8)	(18.3)	(98.8)	(18.3)	(3.5)	(3.5)	0.0	0.0	(3.5)
Liverpool Women's	(28.5)	(28.5)	0.0	(28.5)	(0.0)	(28.5)	(0.0)	0.0	0.0	(0.8)	0.8	0.0
Mersey Care	7.1	7.1	0.0	7.1	(0.0)	7.1	(0.0)	0.0	0.0	(1.0)	1.0	0.0
Mid Cheshire Hospitals	(35.6)	(38.8)	(3.2)	(39.1)	(3.5)	(38.6)	(3.0)	0.2	(0.3)	(0.5)	1.0	0.2
Mersey & West Lancs	(26.7)	(26.6)	0.0	(26.6)	0.0	(26.6)	0.0	0.0	0.0	(0.7)	0.7	0.0
The Clatterbridge Centre	0.9	0.9	0.0	0.9	0.0	0.9	0.0	0.0	0.0	0.0	0.0	0.0
The Walton Centre	5.3	5.3	0.0	5.3	0.0	5.3	0.0	0.0	0.0	0.0	0.0	0.0
Warrington & Halton Hospitals	(27.8)	(34.8)	(7.0)	(36.4)	(8.6)	(36.4)	(8.6)	(1.6)	(1.6)	0.0	0.0	(1.6)
Wirral Community	6.5	6.5	0.0	6.5	0.0	6.5	0.0	0.0	0.0	(0.2)	0.2	0.0
Wirral University Hospitals	(16.3)	(22.9)	(6.6)	(23.3)	(7.0)	(23.3)	(7.0)	(0.4)	(0.4)	0.0	0.0	(0.4)
TOTAL (C&M Providers)	(212.3)	(244.8)	(32.4)	(253.8)	(41.5)	(252.9)	(40.6)	(8.2)	(8.6)	(4.0)	4.4	(8.2)
C&M ICB	62.4	37.5	(24.9)	30.4	(32.0)	30.4	(32.0)	(7.1)	0.0	0.0	(7.1)	(7.1)
TOTAL ICS	(150.0)	(207.3)	(57.3)	(223.4)	(73.5)	(222.6)	(72.6)	(15.3)	(8.6)	(4.0)	(2.8)	(15.3)

2.10 It should be noted that a £229.5m Month 8 YTD deficit (excluding deficit support) exceeds the full year £150m deficit plan within the first seven months of the year. This reflects the challenging profile of the plan where CIPs have been assumed to deliver towards the end of the year as well as a number of planned transactions in Month 12. The current run rate will need to improve significantly in order for the system plan to be achieved and so focus and acceleration of CIP plans and expenditure run rate reductions will be critical over the next few weeks to support the recovery trajectories and mitigate the £72.6m gap.

2.11 This risk value has been reported to NHS England and discussed via the regulator assurance and intervention meetings.

3. Financial Performance Month 8

ICS financial performance – M8

- 3.1 As of 30th November 2024 (Month 8), the ICS is reporting a YTD deficit of £129.5m against a planned YTD deficit of £62.1m resulting in an adverse YTD variance of £67.4m. Following the receipt of £150m system deficit funding, the system plan is now a breakeven position and therefore the YTD deficit of £129.5m must be recovered over the remaining 4 months of the year in order to achieve the revised plan.
- 3.2 The YTD variance against plan is due to a deterioration of both the ICB position and key pressures within providers. ICB pressures continue in relation to the cost of Continuing Health Care (CHC) and Mental Health packages. Pressures on prescribing budgets have also continued following the receipt of the latest prescribing data. Recovery actions across a range of areas have been delivered and secured within the position during the month however the benefit is being offset by these continued pressures. Provider pressures relate primarily to the impact of industrial action in June and July, under-delivery of efficiency savings, underperformance on ERF targets at Wirral Teaching Surgical Centre, the cost of the review at Countess of Chester and the impact of the cyber-attack at Wirral Teaching in November
- 3.3 **Table 3** sets out the financial performance surplus/(deficit) at Month 8 at organisation level.

Table 3 – ICS Financial Performance M8 YTD by organisation

Financial performance surplus/(deficit) for the purposes of system achievement (excluding £150m deficit support)	M8 YTD Plan	M8 YTD Actual	M8 YTD Variance	M8 YTD Variance	M8 YTD Actual (excluding 8/12ths of £150m deficit support)	Full Year Annual Plan (exc £150m deficit support)	Month 8 YTD as a % of FY plan
	£m	£m	£m	%	£m	£m	%
C&M ICB	41.5	0.8	(40.7)	-0.8%	0.8	62.3	1%
Alder Hey Children's	0.1	(0.5)	(0.6)	-0.2%	(0.5)	3.4	-15%
Bridgewater Community	0.7	(1.8)	(2.5)	-3.8%	(1.8)	2.1	-86%
Cheshire & Wirral Partnership	0.5	0.8	0.2	0.1%	0.8	1.5	51%
Countess of Chester Hospitals	(8.2)	(14.9)	(6.7)	-2.8%	(24.2)	(23.6)	103%
East Cheshire Trust	(6.2)	(6.5)	(0.3)	-0.2%	(12.1)	(14.4)	84%
Liverpool Heart & Chest	8.8	8.4	(0.4)	-0.3%	8.4	14.1	59%
Liverpool University Hospitals	(59.4)	(65.2)	(5.7)	-0.7%	(97.0)	(80.5)	120%
Liverpool Women's	(8.4)	(7.8)	0.6	0.6%	(19.0)	(28.5)	67%
Mersey Care	3.8	3.8	0.0	0.0%	3.8	7.1	53%
Mid Cheshire Hospitals	(8.0)	(10.1)	(2.1)	-0.8%	(24.2)	(35.6)	68%
Mersey & West Lancs	(14.9)	(12.0)	2.9	0.5%	(22.5)	(26.7)	84%
The Clatterbridge Centre	0.4	0.4	0.0	0.0%	0.4	0.9	48%
The Walton Centre	3.5	4.0	0.5	0.4%	4.0	5.3	75%
Warrington & Halton Hospitals	(11.8)	(13.3)	(1.5)	-0.6%	(24.3)	(27.8)	87%
Wirral Community	1.3	1.3	0.0	0.0%	1.3	6.5	19%
Wirral University Hospitals	(5.9)	(16.9)	(11.0)	-3.2%	(23.3)	(16.3)	143%
Total C&M ICS	(62.1)	(129.5)	(67.4)	-1.3%	(229.5)	(150.0)	153%

ICB Financial Performance – M8

3.4 The ICB has reported a YTD surplus of £0.8m compared to a planned surplus of £41.5mm, resulting in an adverse variance to plan of £40.7m as per **Table 4** below.

Table 4 – ICB Financial Performance M8 YTD

	M8 YTD			
	Plan £m	Actual £m	Variance £m	Variance %
ICB Net Expenditure				
Acute Services	2,450.3	2,447.7	2.6	0.1%
Mental Health Services	471.6	491.9	(20.4)	(4.3%)
Community Health Services	469.3	464.5	4.8	1.0%
Continuing Care Services	269.1	291.3	(22.2)	(8.3%)
Primary Care Services	428.7	440.9	(12.1)	(2.8%)
Other Commissioned Services	10.3	9.7	0.6	6.2%
Other Programme Services	41.3	39.3	2.0	4.8%
Reserves / Contingencies	(2.4)	0.0	(2.4)	100.0%
Delegated Specialised Commissioning	405.0	399.9	5.2	1.3%
Delegated Primary Care Commissioning	573.3	572.1	1.2	0.2%
Primary Medical Services	376.7	376.0	0.8	0.2%
Dental Services	128.3	125.5	2.8	2.2%
Ophthalmic Services	17.8	18.3	(0.5)	(2.7%)
Pharmacy Services	50.4	52.4	(1.9)	(3.8%)
ICB Running Costs	29.3	29.2	0.0	0.1%
Total ICB Net Expenditure	5,145.9	5,186.6	(40.7)	(0.8%)
Allocation adjustment for reimbursable items	0.0	0.0	0.0	0
TOTAL ICB Surplus/(Deficit)	41.5	0.8	(40.7)	(0.8%)

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

- a) Continuing Healthcare – escalating pressures linked to cost and volume of eligible CHC clients exceeding planning assumptions. An adverse variance of £22.2m is reported at Month 8 which represents an increase of £3.8m compared to the previous month.
- b) Mental Health Services – overspend of £20.4m reported at Month 8 of which £19.4m relates to packages of care compared to a £15.7m pressure at month 7.

The current forecast adverse variance to plan for Continuing Healthcare is £34.9m and £29.9m for complex packages of care, both of which have worsened in month. **Appendix 1** contains details of the forecast variance by place and shows the key drivers for the pressure.

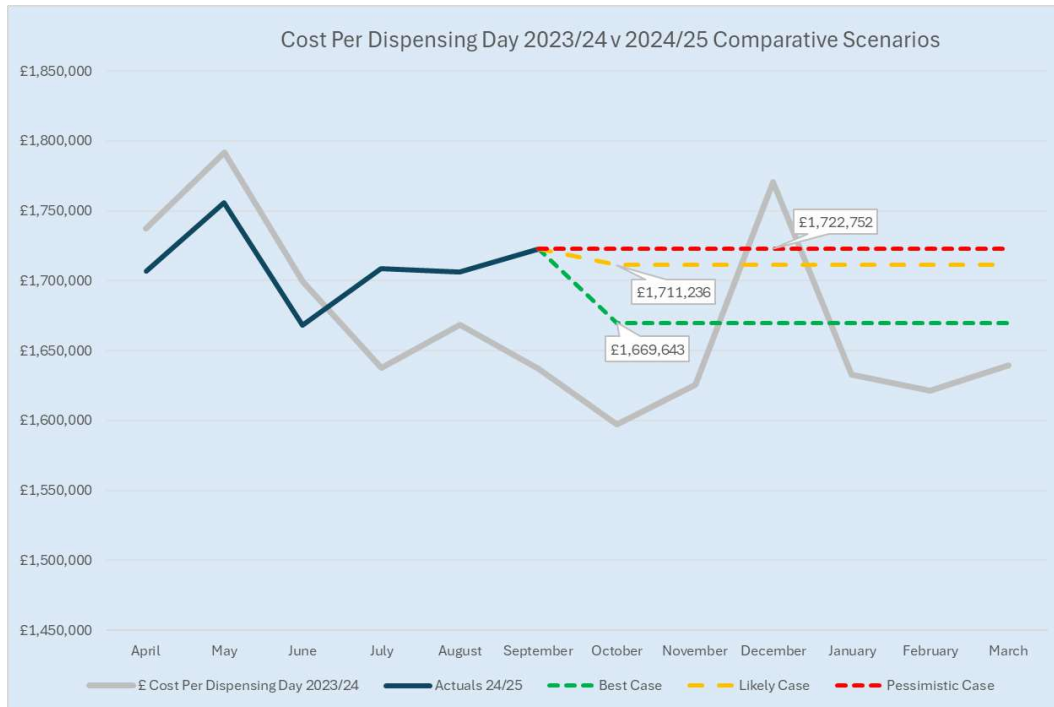
- c) A pressure of £16.2m is reported on the prescribing budget at Month 8 based on September-24 prescribing data. This represents a £7.4m adverse movement from plan during the month, however this is largely due to costs being included in the month 8 position that were previously regarded as risk. At this stage in the year, based on an assessment of the forecast, the risk is considered to have crystallised and is therefore included within the year to date position for the first time.

Further analysis on the cost per prescribing day is included in chart 2 within paragraph 3.6.

- d) Reserves – The month 8 position includes a £2.4m pressure on reserves. This is recognition of the pressure on place reserve budgets where some places have efficiency challenges that are now not likely to be delivered within the remaining months of the year.
- e) Running costs - Costs remain within the running cost allowance following the reduction in allocation this year. A further 10% reduction will be made to the running cost allowance in 2025/26.
- f) Other – Net favourable movements of £6.4m have been recorded in-month across all other areas, primarily within community and primary care budgets.
- g) Efficiency – The ICB reports a £7.4m shortfall against the planned efficiency savings plans for month 8 which is a small improvement in-month. Key areas of slippage are within pathway transformation (£1.7m) and prescribing efficiencies (£5.2m).

- 3.6 For prescribing **Chart 2** shows that the cost per prescribing day were lower in April, May and June than the previous year, however in July to September costs have been on average 3.9% higher than last year leading to expenditure outstripping planning assumptions. The most likely case forecast assumes that the increased cost per prescribing day continues for the remainder of the year, influenced by NCSO (No cheaper stock obtainable) pressures.

Chart 2 – Cost per Prescribing Day



3.7 Details of ICB performance split by place is shown below, and more detail is provided in **Appendix 2. Table 5** sets out in summary the Month 8 Place performance:

Table 5 – Place M8 – Financial Performance

	M8 YTD Plan £000's	M8 YTD Actual £000's	M8 YTD Variance £000's
Cheshire - East	(34,689)	(42,700)	(8,012)
Cheshire - West	(28,428)	(32,556)	(4,128)
Halton	(6,253)	(8,492)	(2,239)
Knowsley	7,909	6,981	(928)
Liverpool	7,073	(2,439)	(9,512)
Sefton	(7,009)	(15,316)	(8,307)
St Helens	(7,426)	(9,693)	(2,267)
Warrington	(3,074)	(4,271)	(1,197)
Wirral	(13,814)	(23,768)	(9,954)
ICB	127,237	133,059	5,822
Total ICB	41,527	806	(40,721)

Provider Financial Performance – M8

3.8 **Table 6** below sets out the ICS Month 8 YTD financial position, split by individual provider alongside ICB position.

Table 6 – ICS M8 Financial Performance

Financial performance surplus/(deficit) for the purposes of system achievement (excluding £150m deficit support)	M8 YTD Plan	M8 YTD Actual	M8 YTD Variance	M8 YTD Variance	M8 YTD Actual (excluding 8/12ths of £150m deficit support)	Full Year Annual Plan (exc £150m deficit support)	Month 8 YTD as a % of FY plan
	£m	£m	£m	%	£m	£m	%
C&M ICB	41.5	0.8	(40.7)	-0.8%	0.8	62.3	1%
Alder Hey Children's	0.1	(0.5)	(0.6)	-0.2%	(0.5)	3.4	-15%
Bridgewater Community	0.7	(1.8)	(2.5)	-3.8%	(1.8)	2.1	-86%
Cheshire & Wirral Partnership	0.5	0.8	0.2	0.1%	0.8	1.5	51%
Countess of Chester Hospitals	(8.2)	(14.9)	(6.7)	-2.8%	(24.2)	(23.6)	103%
East Cheshire Trust	(6.2)	(6.5)	(0.3)	-0.2%	(12.1)	(14.4)	84%
Liverpool Heart & Chest	8.8	8.4	(0.4)	-0.3%	8.4	14.1	59%
Liverpool University Hospitals	(59.4)	(65.2)	(5.7)	-0.7%	(97.0)	(80.5)	120%
Liverpool Women's	(8.4)	(7.8)	0.6	0.6%	(19.0)	(28.5)	67%
Mersey Care	3.8	3.8	0.0	0.0%	3.8	7.1	53%
Mid Cheshire Hospitals	(8.0)	(10.1)	(2.1)	-0.8%	(24.2)	(35.6)	68%
Mersey & West Lancs	(14.9)	(12.0)	2.9	0.5%	(22.5)	(26.7)	84%
The Clatterbridge Centre	0.4	0.4	0.0	0.0%	0.4	0.9	48%
The Walton Centre	3.5	4.0	0.5	0.4%	4.0	5.3	75%
Warrington & Halton Hospitals	(11.8)	(13.3)	(1.5)	-0.6%	(24.3)	(27.8)	87%
Wirral Community	1.3	1.3	0.0	0.0%	1.3	6.5	19%
Wirral University Hospitals	(5.9)	(16.9)	(11.0)	-3.2%	(23.3)	(16.3)	143%
Total C&M ICS	(62.1)	(129.5)	(67.4)	-1.3%	(229.5)	(150.0)	153%

3.9 There are 9 Trusts reporting a year-to-date adverse variance to plan. An explanation of the key drivers of the YTD variances are set out below:

- Alder Hey Children's NHS Foundation Trust**
£0.6m adverse variance YTD, forecast to plan.
 The key driver of the £0.6m YTD variance is linked to the unfunded element of the pay award driven by differential skill mix than national assumptions. The trust is continuing to review its run rate and forecast to mitigate this position
- Bridgewater Community NHS Foundation Trust**
£2.5m adverse variance YTD, risk adjusted FOT £2m adverse to plan.
 Key drivers of the £2.5m YTD variance are operational issues linked with premium paediatric locum spend and other demand led pay pressures £2.0m; £1.1m adverse YTD CIP variance; which is partially offset by £0.6m non recurrent items relating to prior year.
 Whilst the trust has not yet formally changed its FOT to NHSE it has reported a risk adjusted forecast of £2.0m adverse to plan due to under-achievement of integration savings with Warrington. This is being escalated and addressed through the phase 2 intervention process.

- Countess of Chester NHS Foundation Trust**
£6.7m adverse variance YTD, risk adjusted FOT £1.8m adverse to plan
 £0.7m of the YTD variance is attributable to industrial action. Key drivers of the remaining £6.0m YTD variance are largely attributable to the YTD costs in relation to public enquiry of £4.3m. The trust is reporting an adverse CIP YTD variance from £4.9m against the plan, offset by budgetary underspends elsewhere. The trust's assessment of the impact of the pay award is a c£1.8m in year pressure, of which £1.2m is reflected in the YTD position. NHSE region have indicated it would like to undertake a targeted review over December on those providers reporting a material pay award pressures, including the Countess of Chester.
 Whilst the trust has not yet formally changed its FOT to NHSE it has reported a risk adjusted forecast of £1.8m adverse to plan, directly linked to the impact of the pay award.
- East Cheshire NHS Trust**
£0.3m adverse variance YTD, forecast to plan
 The £0.3m adverse to plan is attributable to £0.2m unfunded industrial action cost and loss of income and £0.1m of costs relating to support for medically fit mental health patients as well as additional costs from the independent sector related to increased activity.
- Liverpool Heart & Chest Hospital NHS Foundation Trust**
£0.4m adverse variance YTD, forecast to plan
 Key drivers of the £0.5m YTD variance are: £1.5m undelivered recurrent CIP; £0.6m from a delay in the expansion of targeted lung programme which the trust host across the ICS, the trust is expecting to see a significant increase in the scanning of patients across Wirral, Warrington and North Sefton that will attract associated income as planned; and £1.1m from inflation above planning assumptions across licensed drugs and cath lab consumables. These pressures have been partially offset by £1.5m non-recurrent technical items over the first three months and £1.7m overperformance on inter system activity.
- Liverpool University Hospitals NHS Foundation Trust**
£5.7m adverse variance YTD, £18.3m risk adjusted FOT adverse to plan
 £1m of the YTD variance is attributable to industrial action net of funding received. Key drivers of the remaining £4.7m YTD variance are: £7.6m undelivered CIP, £2.3m pay award impact and £4m other operational pressures on non pay; offset by c£9.0m expected ERF overperformance, non-recurrent technical items and balance sheet release.
 Whilst the trust has not yet formally changed its FOT to NHSE it has reported a risk adjusted forecast of £18.3m adverse to plan. This is attributable to trust assessed impact of the pay award £3.5m and £14.8m non-delivery of CIP associated the no criteria to reside patients. This is being escalated and addressed through the phase 2 intervention process.
- Mid Cheshire Hospitals NHS Foundation Trust**
£2.1m adverse variance YTD, £3.3m risk adjusted FOT adverse to plan

£0.2m of the YTD variance is attributable to industrial action. Key drivers of the remaining £1.9m YTD variance are: £3.7m under delivery on CIP plan YTD, £2.1m operational pressures linked to continuation of escalation capacity, offset by £2.5m of additional income associated with ERF and commercial activities, and a £1.5m benefit of planned EPR implementation being delayed until later in the financial year.

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

- **Warrington and Halton Teaching Hospitals NHS Foundation Trust**
£1.5m adverse variance YTD, £8.6m risk adjusted FOT adverse to plan
The £1.5m adverse variance to date relates to; £0.7m impact of industrial action over June and July; and £0.5m adverse impact from the pay award. This is a net adverse variance after the distribution of funding via NHSE for industrial action and pay award uplifts.
Whilst the trust has not yet formally changed its FOT to NHSE it has reported a risk adjusted forecast of £8.6m adverse to plan. The £8.6m risk adjusted forecasts is driven by £7.0m delay on CIP and local integration plans, and £1.6m pay award impact. This is being escalated and addressed through the phase 2 intervention process.

- **Wirral University Teaching Hospitals NHS Foundation Trust**
£11.0m adverse variance YTD, £7.0m risk adjusted FOT adverse to plan

£0.5m of the YTD variance is attributable to industrial action. Key drivers of the remaining £10.5m YTD variance are; £11.4m elective underperformance across surgical specialties T&O and Urology driven by under-utilisation of C&M Surgical Centre by system partners, consultant vacancies and CSSD downtime; £2.4m acute pay overspend within ED medical and ED nursing driven primarily by corridor care, with work on-going to review rotas and how to reduce shifts subject to escalated rates of pay; £3m impact and loss of income resulting from cyber-attack. The above has been mitigated to an extent by c.£1m of underspends and vacancies elsewhere across the Trust, and c.£5m balance sheet release.

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

- 3.10 **Table 7** sets out the provider year-to-date position compared to the Month 8 YTD plans by income, pay, non-pay and non-operating items. This shows that the aggregate YTD pay position is £67.4m (2.4%) adverse to plan, which is explained by; the net cost of medical cover during the industrial action in June and July of c£5.5m (0.2%); undelivered pay efficiencies YTD of £28.0m (1.0%); YTD pay award pressure £7.3m (0.3%); and selected operational pay pressures and underspends across several providers as set out in section 3.11 above (0.9%). NHS Providers are also reporting additional non pay inflation across drugs and consumables above those assumed in the plan and is a key contributor to the 7.0% YTD adverse variance on non-pay expenditure which requires further investigation. The remaining driver impacting non pay is a shortfall on YTD

efficiency delivery of £13.6m (1.0%). A full breakdown of the expenditure variance by provider can be found in **Appendix 3**.

Table 7 – Provider Income and Expenditure vs YTD Plan

	M8 YTD			
	Plan	Actual	Variance	
	£m	£m	£m	%
Total Income	4,384.3	4,514.3	130.0	3.0%
Pay	(2,992.9)	(3,060.3)	(67.4)	-2.3%
Non Pay	(1,430.9)	(1,530.5)	(99.5)	-7.0%
Non Operating Items (excl gains on disposal)	(64.2)	(53.9)	10.3	16.0%
Total Provider Surplus/(Deficit)	(103.7)	(130.3)	(26.7)	0.6%

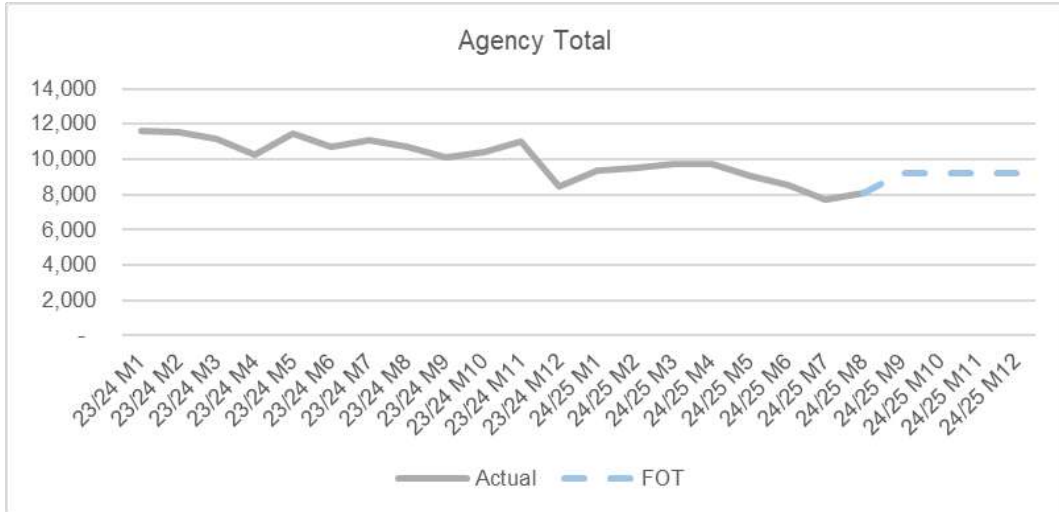
NHS Provider Agency Expenditure

- 3.11 ICS NHS Providers set a plan for agency spend of £91.8m, compared to actual spend in 2023/24 of £128.5m. The System is required to manage agency costs within a ceiling and to demonstrate reduced reliance on agency staffing year on year. The ICS agency ceiling for 2024/25 is £120.6m.
- 3.12 Agency spend is being closely monitored with approval required from NHS England for all non-clinical agency.
- 3.13 At Month 8, year to date agency spend is £71.7m (£8.7m above plan), equating to 2.3% of total pay. Nine Trusts are reporting a year-to-date adverse variance to plan. Trust level information on agency spend can be found in **Appendix 4**.
- 3.14 **Table 8** below sets out the aggregate agency performance as a system. This indicates providers are forecasting a £16.5m adverse variance to plan however remain within the national agency cap by £12.0m. **Chart 3** below sets out the agency expenditure monthly run rate from 23/24 to YTD Month 8 indicating a downward trajectory on track to deliver the forecast. Further work is ongoing in this area with providers and forms a key part of provider CIP plans and reductions in variable pay.

Table 8 – Provider Agency Expenditure

Agency Position against ICS ceiling	Plan	Actual	Variance	Plan	FOT	Variance
	YTD	YTD	YTD	FY	FY	FY
	£m	£m	£m	£m	£m	£m
All Providers Agency spend	(63.0)	(71.7)	(8.7)	(92.0)	(108.6)	(16.5)
ICS Agency Ceiling				(120.6)	(120.6)	
Variance to Ceiling				28.6	12.0	
Agency as a % of pay		2.3%			2.4%	

Chart 3 – Agency Expenditure Run Rate



Workforce

3.15 Workforce and its triangulation with finance, performance and productivity will continue to be key focus across the system. **Chart 4** sets out the provider WTEs run rate across 23/24 to Month 8 YTD 24/25 and the planned aggregate planned reductions forecast to the end of the year. **Appendix 5** sets out in more detail the movements at provider level.

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

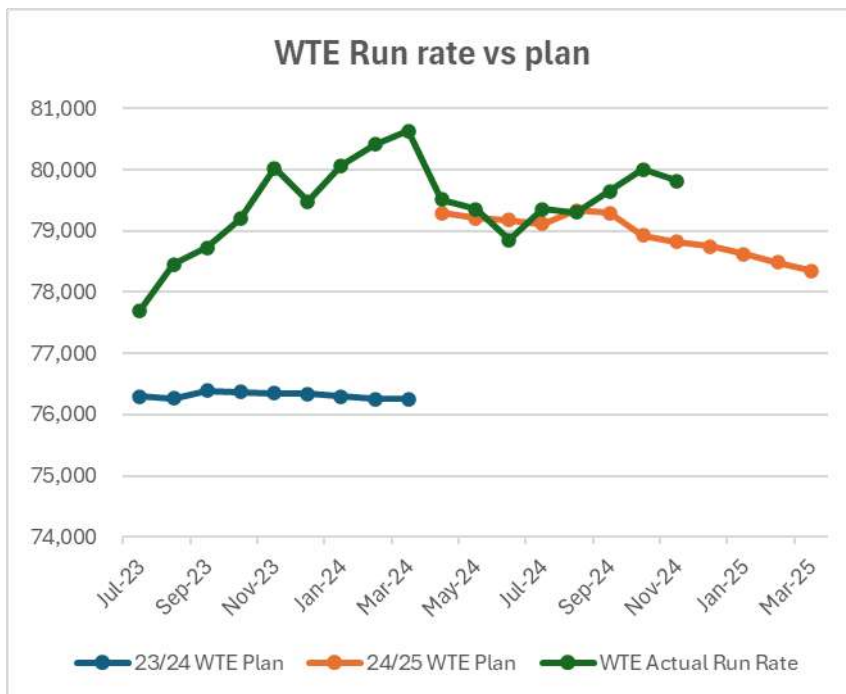







Table 9 – M8 Workforce movements vs M12 23/24 and M8 24/25 Plan

Workforce (WTEs) - source PWRs / mitigation plan submission	M12 Actuals	M1 Actual	M2 Actual	M3 Actual	M4 Actual	M5 Actual	M6 Plan	M6 Actual	M7 Actual	M8 Actual	M1 to M8 Trend	M8 Variance from plan trajectory favourable / (adverse)		M12 Plan (March 25)	Futher change expected M8-12 increase / (decrease)
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE		WTE	%	WTE	WTE
C&M Providers Total	80,465	79,516	79,361	78,849	79,352	79,303	79,297	79,645	80,002	79,822		(999)	-1.3%	78,354	(1,468)

by Sector

Acute	50,353	49,719	49,687	49,296	49,704	49,604	49,503	49,616	49,868	49,637		(525)	-1.3%	48,688	(949)
Specialist	11,423	11,353	11,386	11,431	11,382	11,436	11,461	11,495	11,628	11,645		(227)	-1.9%	11,384	(261)
Community / MH	18,689	18,444	18,289	18,123	18,265	18,263	18,332	18,534	18,506	18,539		(248)	-1.2%	18,282	(258)
TOTAL Providers	80,465	79,516	79,361	78,849	79,352	79,303	79,297	79,645	80,002	79,822		(999)	-1.3%	78,354	(1,468)

3.16 The Month 8 provider workforce data indicates there is a 999 WTE adverse position against the YTD plan. Based on recently revised workforce trajectories providers are planning a further 1,468 WTEs reduction to forecast by March 2025. This does not fully triangulate with the YTD CIP pay being adverse to plan and the forecast reduction in workforce does not fully align with the forecast reductions in pay expenditure to support plan delivery. As part of the investigation and intervention Phase 2 work the workforce trajectories and pay controls are being reported and reviewed on a weekly basis for all providers.

System Efficiencies

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

3.18 **Table 10** shows at Month 8 there is currently a shortfall on planned CIP delivery of £22.4m against the ICS YTD plan, with £15.1m attributable against providers and £7.3m against the ICB. The £235.3m efficiencies delivered YTD represent 4.5% of provider and ICS YTD expenditure/allocation against the annual plan of 6.1%, indicating a larger proportion of the savings required in the remaining months.

3.19 Furthermore only 53% of the system efficiencies YTD plan have been delivered recurrently as at Month 8. This increases the risk in the underlying financial position of the ICS and is subject to ongoing work by providers to both recover the YTD shortfall and address the recurrent position.

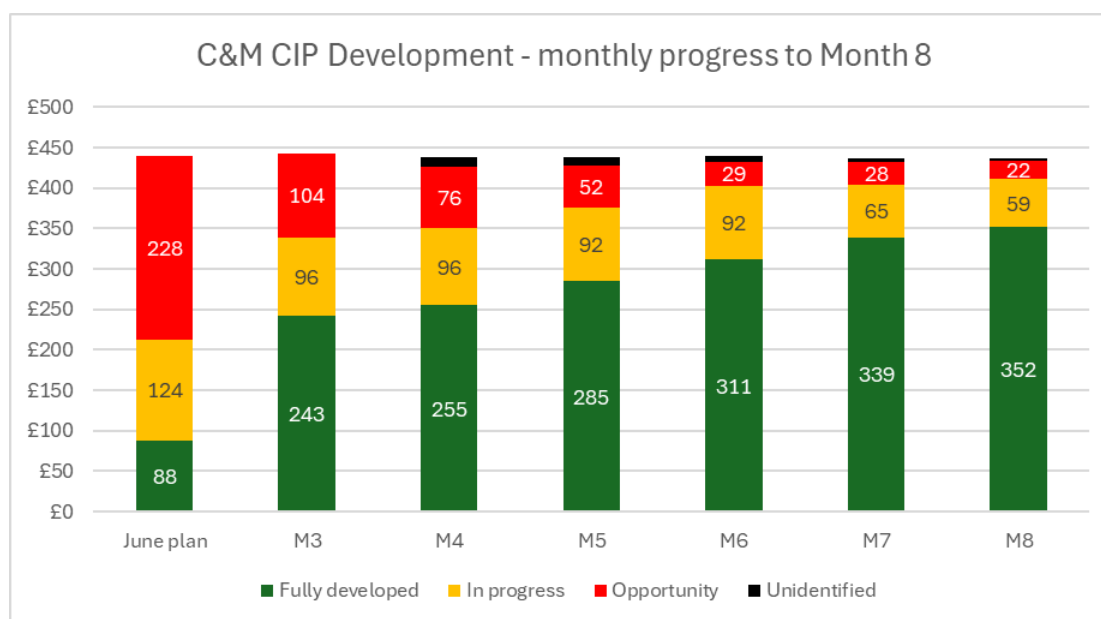
3.20 More detail on System efficiencies, by organisation, is included in **Appendix 6A**.

Table 10 – ICS M8 YTD Efficiency Delivery

Org	CIP delivery						CIP Recurrent / Non Recurrent YTD			YTD CIP Profile as a % of FY CIP Plan		
	M8 YTD Plan	M8 YTD Actual	M8 YTD Variance	M8 YTD % Variance	M8 CIP actual as a % of Op Ex	FY CIP Plan % of Op Ex	M8 YTD Actual Recurrent	M8 YTD Actual Non Recurrent	M8 Actual Recurrent as a % of YTD plan	M8 FOT	Variance to plan	M8 YTD CIP as a % of FY CIP plan
	£,000	£,000	£,000	%	%	%	£,000	£,000	%	£,000	£,000	%
Alder Hey Children's	11,269	11,804	535	5%	3.9%	4.6%	7,805	3,999	69%	19,950	(0)	59%
Bridgewater Community	2,952	1,894	(1,058)	-36%	2.6%	6.7%	504	1,390	17%	6,939	0	27%
Cheshire & Wirral Partnership	8,806	7,971	(835)	-9%	4.0%	4.7%	2,907	5,064	33%	13,913	0	57%
Countess of Chester Hospitals	11,431	6,574	(4,857)	-42%	2.4%	5.1%	6,574	0	58%	19,822	0	33%
East Cheshire Trust	6,025	6,033	8	0%	3.8%	4.9%	2,823	3,211	47%	11,225	0	54%
Liverpool Heart & Chest	6,781	5,013	(1,768)	-26%	3.0%	4.5%	3,830	1,183	56%	10,644	0	47%
Liverpool University Hospitals	60,486	52,804	(7,682)	-13%	5.5%	8.3%	30,387	22,417	50%	114,600	(0)	46%
Liverpool Women's	3,397	4,384	987	29%	3.5%	3.2%	1,688	2,696	50%	5,904	0	74%
Mersey Care	17,311	17,311	0	0%	3.3%	3.5%	16,060	1,251	93%	25,967	0	67%
Mid Cheshire Hospitals	14,039	11,153	(2,886)	-21%	3.7%	5.0%	7,174	3,979	51%	22,437	0	50%
Mersey & West Lancs	26,670	28,537	1,867	7%	4.4%	4.6%	20,670	7,867	78%	47,965	2,800	63%
The Clatterbridge Centre	6,667	6,667	0	0%	3.2%	3.4%	3,586	3,081	54%	10,000	0	67%
The Walton Centre	5,666	5,666	0	0%	4.1%	4.5%	5,086	580	90%	8,558	0	66%
Warrington & Halton Hospitals	9,540	9,716	176	2%	3.6%	4.9%	7,249	2,467	76%	19,433	(0)	50%
Wirral Community	3,674	4,066	392	11%	5.5%	5.8%	928	3,138	25%	6,275	(0)	65%
Wirral University Hospitals	16,724	16,724	0	0%	4.5%	5.0%	11,677	5,047	70%	26,878	(0)	62%
TOTAL Providers	211,438	196,318	(15,120)	-7%	4.3%	5.5%	128,948	67,370	61%	370,509	2,799	53%
C&M ICB	46,357	38,993	(7,364)	-16%	0.8%	1.0%	38,993	0	84%	66,226	(6,010)	54%
TOTAL ICS System	257,795	235,311	(22,484)	-9%	4.5%	6.1%	167,941	67,370	65%	436,735	(3,211)	53%

3.21 **Chart 5** sets out the current risk and development status of efficiency schemes and how this has progressed since the June plan submission. As at Month 8 10% (£43m) of the CIP schemes are currently deemed high risk meaning there is still work to be undertaken the de-risk CIP delivery to support financial plan delivery. As part of the investigation and intervention Phase 2 work the CIP pipeline and delivery status of all CIP schemes is being reported and reviewed on a weekly basis for all providers. Further detail of the risk status of CIP at organisational level is included in **Appendix 6B**.

Chart 5 – CIP Risk status at Month 8 (ICS Position)



Productivity

- 3.22 The 2024/25 planning guidance set out an expectation for all providers, with a focus on the acute sector, to improve towards pre-pandemic levels (recognising potential adjustments for case mix change, structural factors and uncaptured activity). ‘Implied Productivity Growth’ of acute and specialist trusts is calculated by NHSE by comparing output growth (activity) to input growth (based on expenditure costs) against a baseline period. The measure examines the current year’s YTD activity and costs with the same period in 19/20 and more recently, with 23/24. A negative value implies decreased productivity whilst positive implies productivity growth.
- 3.23 The most recently available comparative productivity data is from M6 24/25, and **Table 11** below sets out the aggregate position across all C&M acute and specialist providers compared to the national average. **Appendices 7A and 7B** sets out the position at a provider level.

Table 11 - Implied Productivity Growth M6

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

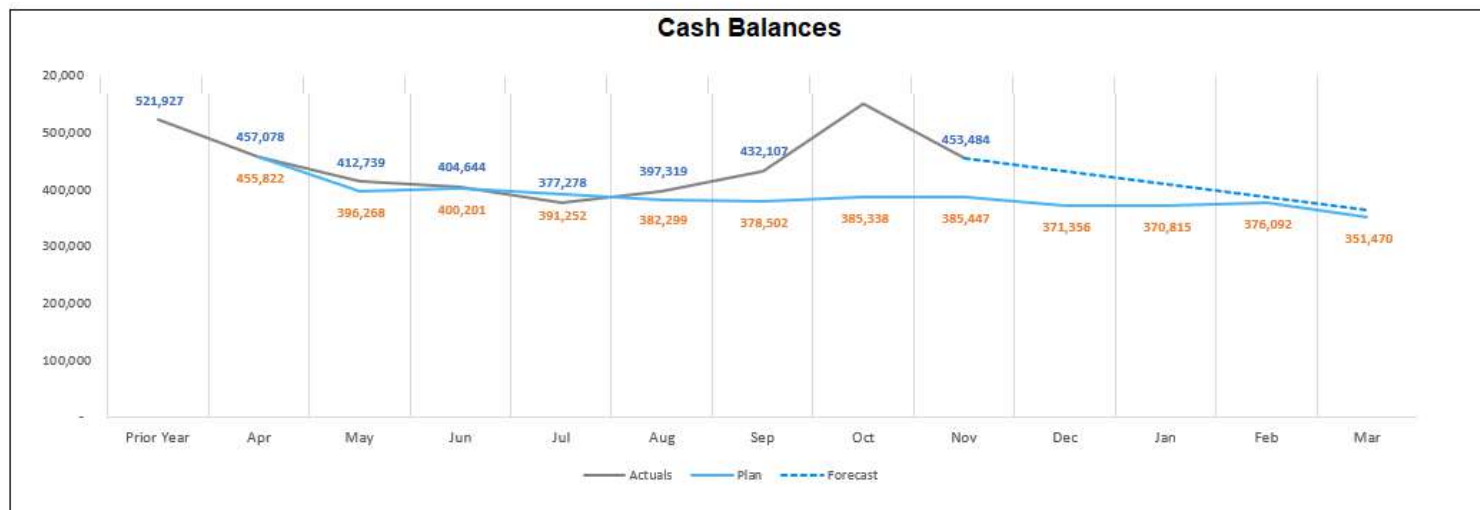
*acute providers only

- 3.24 NHSE have launched a number of workforce diagnostic productivity tools and core productivity metrics to identify and benchmark opportunities for improvement. A summary of the current available C&M system productivity metrics vs national averages, available from NHS Model System, are set out in **Appendix 7C**.

Cash

- 3.25 The Providers’ cash position at Month 8 was £453.5m, with the detail set out in **Appendix 8**. This is £67.1m lower than at the end of 2023/24 and includes £95m of external NHSE cash support received up to and including Month 8 supporting several acute organisations. Acute organisations with a planned deficit have received 8/12ths of the £150m deficit support funding in October which has driven the improvement in the cash position in the month of Month 7. **Chart 6** sets out the aggregated providers month on month cash balances up to Month 8.

Chart 6 – Aggregate Provider cash balances month on month



3.26 There are six organisations that have formally received external cash support from NHSE up to Month 7 of 2024/25 to support their I&E deficit plans – Mersey and West Lancs Teaching NHS Trust, Mid Cheshire Hospitals NHST, Warrington & Halton Teaching Hospitals FT, Liverpool Women’s NHS FT, Liverpool University Hospitals NHS FT and Countess of Chester Hospital NHS FT. Wirral Teaching and East Cheshire trusts are also forecasting cash support requirements in H2 of 2024/25. **Table 12** below set out the aggregate provider cash balance at Month 8, the level of distress cash requests received by NHSE to date and the Month 8 average Better Payment Practice Code (BPPC) position across providers. The aggregate provider BPPC performance has deteriorated from an average number of 93.2% of bills paid within the 95% target at M12 2023/24 to an average number of 89.9% at Month 8. Further detail of BPPC performance by provider is set put in **Appendix 9**.

Table 12 – Provider Cash and BPPC Performance – Month 8

Org	Cash Balance			External Cash Support*		BPPC % of bills paid in target	
	2023/24	2024/25	Movement	Received as at M8	FOT	2024/25 M8	2024/25 M8
	M12	M8				By number	By Value
	Closing Cash Balance	Closing Cash Balance		£m	£m	%	%
TOTAL Providers	520.6	453.5	(67.1)	95.7	132.3	89.9%	93.2%

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

3.27 The BPPC of Wirral UTH is of particular concern – it is extremely low and highlights the cash risk that WUTH are managing. The ICB has supported WUTH to date with £8m cash advance. We are aware that WUTH’s application for distress cash in December was initially refused by the national team and whilst an agreement has been reached agreed for January cash it is likely the trust will require further national support in March to ensure they have cash available to pay staff in March.

- 3.28 The review of the cash position by national team has focussed on cash requests above planned deficit levels, workforce and financial recovery trajectories being on track and working capital balances i.e. high levels of receivables.
- 3.29 The ICB has supported WUTH where possible but is constrained by our own levels of cash available. Cash can be transferred between NHS Providers, but this would be a PDC transfer and requires Board approval.

System Risks and Mitigations

- 3.30 Several risks have been reported through the recent planning progress and are subject to ongoing monitoring and management by the respective organisations:
- a. **Pay Award** – the final pay settlements for medical and agenda for change staff have been agreed and provider plans were set on the basis this would be fully funded. Providers are currently reporting a pay award gap of c£16m. This is a complex area and further clarity will be obtained when the payroll is properly calculated for month-end payments. NHSE are also reviewing a targeted number of organisations who are reporting a material pressure from the pay award.
 - b. **Identification and delivery of recurrent CIPs** – this is subject to weekly reporting as part of the PwC phase 2 governance process.
 - c. **Non-achievement of ERF / activity requirements** – Month 4 data has been made available from NHS England, indicating that C&M ICB is on plan at 112.8%. However, the overperformance lies more within the Independent Sector than C&M NHS Providers, highlighting the risk of not achieving the productivity gains required in the 24/25 financial plans.
 - d. **Inflation** – specifically; non-pay inflation for providers and prescribing and continuing care/packages of care for the ICB above national planning assumptions.
 - e. **Cost of out of area placements** arising from delayed transfers of care.
 - f. **Maintenance of core acute bed base year-round** – targeted improvement plan in development across the System in response to recommendations identified by National team.
 - g. **Industrial action disruption** – the plan assumes no further industrial action throughout 24/25.
 - h. **Depreciation allocation** – There is a link between depreciation expenditure in provider plans and a ringfenced allocation for increases depreciation from a baseline 22/23 position. Any misalignment in assumptions in providers plans could result in a reduction in allocation to the system and impact the financial position.

The risks identified will be address through the actions outlined in the Intervention section of the PwC report.

ICB Recovery Update

3.31 For the ICB the recovery programme targets consist of 3 areas:

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

3.32 The forecast savings against the combined recovery programme targets is £84.7m of which £66.2m relates to the efficiency plans agreed as part of the plan and £18.5m are additional savings identified by the programmes to contribute towards to recovery plan. **Table 13** sets out the latest position by programme.

Table 13 – ICB Recovery Programme Performance – Month 8

Programme Name	YTD			Forecast		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
All Age Continuing Health Care/Complex Care	14,105	12,688	(1,417)	36,464	33,525	(2,939)
Cheshire Urgent Care Improvement	3,309	2,627	(682)	4,965	3,941	(1,024)
Medicines Management	16,778	11,614	(5,164)	30,700	24,625	(6,075)
Mental Health System Flow	0	0	0	10,953	0	(10,953)
Optimising Patient Choice Independent Sector Value	0	0	0	1,800	2,625	825
Unwarranted Variation	281	380	99	520	759	239
Workforce Optimisation	6,616	6,616	0	10,924	10,924	0
Other	5,560	5,447	(113)	8,750	8,311	(439)
TOTAL	46,649	39,372	(7,277)	105,076	84,710	(20,366)

ICB Risk Adjusted Forecast

3.33 Following the review with the NHSE Nominated lead the ICB highlighted a likely scenario of £25m adverse to plan that needed significant further mitigations actions in order to achieve the annual plan. **Table 14** below provides a summary of the ICB financial forecast for 2024/25 as at Month 8 and represents the latest most likely scenario.

Table 14 - ICB Forecast Risks and Mitigations

ICB Forecast Risk and Mitigation - Cheshire & Merseyside		
ICB Planned Position +/-	£m	
	Forecast Outturn	Risks
	£m	£m
CHC	-34.9	-7.5
MH Packages	-29.9	-5.4
Prescribing	-24.8	-6.7
Primary Care	-6.7	-12.8
Other Programme	23.1	-8.8
Total	-73.2	-41.2
Mitigations	£m	
Place Mitigations	25.7	
Medicines Management Recovery Programme	12.7	
Primary Care	12.2	
Other Mitigations	31.8	
Total	82.4	
RISK ADJUSTED FORECAST	30.3	
RISK ADJUSTED VARIANCE TO PLAN	-32.0	

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

- Achievement of the prescribing efficiency plans following agreement to implement a period of overtime for medicines management staff as a result of vacancies and implementation of the prescribing waste campaign.
- Continued focus on reducing inflationary uplifts for packages of care and review of open packages of care with no payments made.
- Negotiation of BCF uplifts and charges from Local Authorities.
- Review of Discharge to Assess/Pathway 3.
- Increased utilisation of estates void space.
- Recovery of further ERF for community services undertaking acute activity and challenge over-performance for non-ERF eligible activity e.g. outpatients.
- Review of discretionary expenditure including contracts due to end.

Table 15 – Mitigations by Place

Area	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Acute	182	23	0	0	0	0	679	60	0	944
Community	0	1,024	194	500	0	1,350	136	80	45	3,329
CHC	0	0	375	779	1,500	6,209	875	101	0	9,839
Mental Health Packages	0	0	110	0	0	0	0	100	3,300	3,510
Mental Health Contracts	0	0	0	0	0	0	0	51	80	131
Other Programme	0	0	0	16	695	290	0	100	0	1,101
Primary Care Delegated	0	0	60	0	0	0	0	0	77	137
Prescribing	768	702	245	735	1,062	518	365	538	770	5,701
Primary Care Other	0	90	0	40	300	614	0	0	0	1,043
	950	1,839	984	2,069	3,557	8,980	2,055	1,030	4,272	25,735

3.35 The ICB DOF continues to hold meetings with each Place finance lead on a monthly basis to review the financial position including updated forecast outturn assessments and the outstanding mitigations being pursued by each place team. There does inevitably remain some level of financial risks to the position as presented, particularly in relation to Prescribing and CHC/Complex Packages expenditure given the activity based nature of the spend but also in respect of residual levels of efficiency which are required in the last few months of the year.

3.36 At this stage in the year, prescribing forecasts are now based on 7 months of data, but prices remain volatile. In addition, the impact of GP collective action on prescribing expenditure is unknown.

ICS Risk Adjusted Forecast, including providers

3.37 A Risk Adjusted Forecast has been collected from each organisation every month so that the impact of individual and collective interventions on the gap can be tracked. The Month 8 mitigated forecast is set out in **Table 16** below:

Table 16 – Risk Adjusted FOT as at M8

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

3.38 There are a number of non-recurrent transactions planned for month 12 which are set out in the table below that produce a significant improvement in month 12. These non-recurrent transactions are being monitored through the weekly FICC during December and are being monitored through direct meetings

between the ICB CFO and each provider CFO. They are set out in the table below:

Description	£m
LUHFT – Benefits arising from Liverpool Acute Trust collaboration	15.0
LUHFT – Legal Claim	27.3
MWL Transaction Support from NHSE and own improvement	8.0
Wirral Community – Benefits arising from Wirral collaboration	3.5
Number of Trusts - Profile of CIP (WHH £7.7m, LUHFT £4m)	15.0
COCH – Thirlwall Enquiry Costs Funding	6.5
TOTAL	75.3

3.39 The system is still being asked to deliver the £150m deficit plan as set out at the start of the year. There remains a number of opportunities and actions being explored in order to improve the financial position of the ICS:

Provider organisation opportunities

- Explore Revenue to Capital transfer opportunities.
- Further external intervention support to 4 high risk providers currently forecasting a gap to plan delivery.
- Continue to review all in-year investments for potential delivery slippage.
- Explore capital incentivisation for improved financial positions for organisations in surplus.
- Review liabilities and deferred income across all organisations.

ICB opportunities

- Further support to the All Age Continuing Healthcare programme in support of recovery programme activities.
- Continued focus on prescribing expenditure seeking opportunities – additional internal capacity already approved. External review being sought.

3.40 The total range of these opportunities is assessed as up to c.£23m across the ICS/ICB, which would result in a possible overall ICS position of c.£200m deficit compared to current outturn of £223m deficit and planned deficit of £150m.

Provider and Primary Care Capital

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

£315.0m with an expectation that the overprogramming position would be managed in year.

3.42 **Tables 17 & 18** sets out the YTD Month 8 position capital expenditure against plan at a system level but also the ICB's primary care capital position. At Month 8 there is a £28.2m underspend against YTD plan, with a £15.2m forecast variance against full year plan largely in relation to additional spend forecast at the Mid-Cheshire Leighton site to address the ongoing RAAC programme. The ICS has been provided with additional allocation by the national team to continue with the RAAC works. A reconciliation of the changes from Plan to FOT are set out in **Table 19** below.

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

Table 17 - System (Provider & ICB) - Charge against Capital Allocation M8

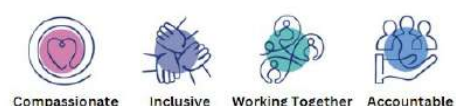
	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Plan Year Ending £'000	FOT Year Ending £'000	Variance Year Ending £'000	%
System charge against allocation	173,165	145,004	28,162	315,026	330,302	(15,276)	-4.8%
Capital allocation					330,302		
Variance to allocation					(0)		
Allocation met					Yes		

Table 18 – ICB - Charge against allocation M7

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

Table 19 – Reconciliation from ICS Capital Plan to ICS Capital FOT M8

	£,000	Comment
Capital Plan (submitted June 2024)	315,026	
<u>Additions funded nationally</u>		
Mid Cheshire RAAC	24,682	Funded by NHSE - priority
Wirral RAAC	1,953	Funded by NHSE - priority
Countess of Chester RAAC	550	Funded by NHSE - priority
<u>Reductions supporting £12m local overprogramming</u>		
Review of IFRS16 leases	(6,909)	various trusts
Mersey Care - L2 scheme slippage	(2,000)	contractual spend now in 25/26
CWP - Mother & Baby Unit slippage	(1,500)	contractual spend now in 25/26
Alder Hey - various schemes slippage	(1,500)	contractual spend now in 25/26
Capital FOT at M8	330,302	



3.44 **Appendix 10** sets out the detailed capital position M8 YTD and FOT by provider.

4. Ask of the Committee and Recommendations

4.1 The Committee is asked to note the financial position and metrics reported at Month 8 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:	Agency Expenditure M8 YTD by provider
Appendix 2:	Workforce Analysis M8 vs M12 trend and M8 Plan by Provider
Appendix 3A:	System Efficiencies: Current Performance M8
Appendix 3B:	System Efficiencies: Risk and Development of CIP Plan M8
Appendix 8:	Provider Cash at Month 8
Appendix 9:	Provider BPPC at Month 8
Appendix 10:	ICS Capital Expenditure YTD and FOT vs ICS Allocation at Month 8

Appendix 1

Agency Costs YTD and FOT	YTD Plan	YTD Actual	YTD Variance	Forecast Outturn Plan	Forecast Outturn Forecast	Forecast Outturn Variance	YTD agency as a % of YTD pay costs %	FOT agency as a % of FOT pay costs %
	£m	£m	£m	£m	£m	£m		
Alder Hey Children's	(0.4)	(1.0)	(0.6)	(0.6)	(1.4)	(0.8)	0.6%	0.5%
Bridgewater Community	(1.2)	(1.5)	(0.3)	(1.5)	(1.7)	(0.2)	3.0%	2.6%
Cheshire & Wirral Partnership	(6.0)	(6.0)	0.1	(8.3)	(8.7)	(0.4)	3.9%	3.9%
Countess of Chester Hospitals	(3.3)	(3.2)	0.1	(4.9)	(4.9)	0.0	1.8%	1.8%
East Cheshire Trust	(4.8)	(4.1)	0.7	(7.3)	(6.5)	0.8	4.0%	4.4%
Liverpool Heart & Chest	(0.6)	(0.4)	0.2	(0.9)	(0.8)	0.1	0.5%	0.6%
Liverpool University Hospitals	(7.6)	(7.8)	(0.2)	(10.0)	(13.7)	(3.7)	1.3%	1.6%
Liverpool Women's	(0.9)	(0.5)	0.4	(1.4)	(0.6)	0.8	0.7%	0.5%
Mersey Care	(12.0)	(11.2)	0.8	(18.0)	(15.5)	2.6	2.9%	2.7%
Mid Cheshire Hospitals	(5.6)	(8.1)	(2.5)	(8.5)	(12.5)	(4.0)	4.0%	4.1%
Mersey & West Lancs	(11.9)	(16.3)	(4.3)	(17.9)	(21.9)	(4.0)	0.0%	0.0%
The Clatterbridge Centre	(0.5)	(0.9)	(0.4)	(0.7)	(1.2)	(0.5)	3.8%	3.4%
The Walton Centre	0.0	(0.5)	(0.5)	0.0	(0.8)	(0.8)	1.2%	1.1%
Warrington & Halton Hospitals	(5.0)	(2.3)	2.7	(7.3)	(7.3)	0.0	0.8%	0.8%
Wirral Community	(0.3)	(0.5)	(0.2)	(0.5)	(1.2)	(0.7)	1.2%	2.8%
Wirral University Hospitals	(2.8)	(7.3)	(4.5)	(4.2)	(10.1)	(5.8)	1.0%	1.5%
TOTAL	(63.0)	(71.7)	(8.7)	(92.0)	(108.6)	(16.5)	2.3%	2.4%

C&M Annual Agency Ceiling
Forecast Variance to Ceiling

(120.6)
12.0

Appendix 2 – Workforce Analysis M8 vs M12 trend and M8 Trajectory Plan by Provider

	2023/24	2024/25										M8 Variance		2024/25	
Workforce (WTEs) - source PWRs / mitigation plan submission	M12 Actuals	M1 Actual	M2 Actual	M3 Actual	M4 Actual	M5 Actual	M6 Plan	M6 Actual	M7 Actual	M8 Actual	M1 to M8 Trend	M8 Variance from plan trajectory favourable / (adverse)		M12 Plan (March 25)	Further change expected M8-12 increase / (decrease)
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE		WTE	%	WTE	WTE
Alder Hey Children's	4,368	4,333	4,347	4,326	4,334	4,292	4,345	4,310	4,400	4,418		(112)	-2.6%	4,273	(144)
Bridgewater Community	1,434	1,453	1,462	1,447	1,454	1,445	1,471	1,459	1,476	1,471		12	0.8%	1,479	8
Cheshire & Wirral Partner	4,072	4,061	4,024	4,017	4,000	3,967	4,032	4,032	4,041	4,014		14	0.4%	4,028	14
Countess of Chester Hosp	4,886	4,849	4,783	4,809	4,829	4,829	4,896	4,848	4,841	4,842		(20)	-0.4%	4,764	(78)
East Cheshire Trust	2,675	2,691	2,633	2,633	2,656	2,697	2,653	2,660	2,668	2,641		31	1.2%	2,625	(16)
Liverpool Heart & Chest	1,912	1,874	1,880	1,898	1,886	1,889	1,900	1,887	1,915	1,904		(8)	-0.4%	1,880	(23)
Liverpool University Hospi	15,448	15,261	15,163	15,041	15,228	15,170	14,900	15,128	15,153	15,119		(362)	-2.5%	14,601	(518)
Liverpool Women's	1,687	1,703	1,718	1,717	1,715	1,748	1,756	1,760	1,783	1,784		(24)	-1.3%	1,764	(19)
Mersey Care	11,623	11,344	11,224	11,091	11,244	11,286	11,263	11,475	11,419	11,474		(211)	-1.9%	11,263	(211)
Mid Cheshire Hospitals	5,687	5,445	5,425	5,398	5,429	5,428	5,373	5,380	5,455	5,455		(102)	-1.9%	5,350	(105)
Mersey & West Lancs	10,614	10,458	10,538	10,478	10,556	10,551	10,648	10,547	10,694	10,621		26	0.2%	10,564	(57)
The Clatterbridge Centre	1,893	1,890	1,919	1,920	1,896	1,906	1,887	1,930	1,921	1,926		(27)	-1.4%	1,907	(18)
The Walton Centre	1,562	1,554	1,522	1,570	1,552	1,600	1,573	1,608	1,608	1,614		(56)	-3.6%	1,559	(56)
Warrington & Halton Hosp	4,786	4,626	4,646	4,637	4,657	4,615	4,708	4,707	4,699	4,658		(68)	-1.5%	4,559	(100)
Wirral Community	1,560	1,587	1,579	1,567	1,566	1,564	1,566	1,568	1,570	1,581		(63)	-4.2%	1,512	(69)
Wirral University Hospitals	6,258	6,389	6,499	6,300	6,350	6,315	6,326	6,344	6,358	6,301		(30)	-0.5%	6,227	(74)
C&M Providers Total	80,465	79,516	79,361	78,849	79,352	79,303	79,297	79,645	80,002	79,822		(999)	-1.3%	78,354	(1,468)

by Sector

Acute	50,353	49,719	49,687	49,296	49,704	49,604	49,503	49,616	49,868	49,637		(525)	-1.3%	48,688	(949)
Specialist	11,423	11,353	11,386	11,431	11,382	11,436	11,461	11,495	11,628	11,645		(227)	-1.9%	11,384	(261)
Community / MH	18,689	18,444	18,289	18,123	18,265	18,263	18,332	18,534	18,506	18,539		(248)	-1.2%	18,282	(258)
TOTAL Providers	80,465	79,516	79,361	78,849	79,352	79,303	79,297	79,645	80,002	79,822		(999)	-1.3%	78,354	(1,468)

Appendix 3A - System Efficiencies: Current Performance M8

Org	CIP delivery												CIP Recurrent / Non Recurrent YTD			YTD CIP Profile as a % of FY CIP Plan		
	M8 YTD Plan	M8 YTD Actual	M8 YTD Variance	M8 YTD % Variance	M2 CIP actual as a % of Op Ex	M3 CIP actual as a % of Op Ex	M4 CIP actual as a % of Op Ex	M5 CIP actual as a % of Op Ex	M6 CIP actual as a % of Op Ex	M7 CIP actual as a % of Op Ex	M8 CIP actual as a % of Op Ex	FY CIP Plan % of Op Ex	M8 YTD Actual Recurrent	M8 YTD Actual Non Recurrent	M8 Actual Recurrent as a % of YTD plan	M8 FOT	Variance to plan	M8 YTD CIP as a % of FY CIP plan
	£,000	£,000	£,000	%	%	%	%	%	%	%	%	%	£,000	£,000	%	£,000	£,000	%
Alder Hey Children's	11,269	11,804	535	5%	2.3%	2.4%	2.8%	3.2%	3.7%	3.7%	3.9%	4.6%	7,805	3,999	69%	19,950	(0)	59%
Bridgewater Community	2,952	1,894	(1,058)	-36%	1.2%	1.6%	1.7%	1.9%	2.7%	2.6%	2.6%	6.7%	504	1,390	17%	6,939	0	27%
Cheshire & Wirral Partnership	8,806	7,971	(835)	-9%	2.7%	2.9%	3.1%	2.8%	3.4%	3.4%	4.0%	4.7%	2,907	5,064	33%	13,913	0	57%
Countess of Chester Hospitals	11,431	6,574	(4,857)	-42%	0.1%	0.7%	1.4%	1.6%	1.8%	1.9%	2.4%	5.1%	6,574	0	58%	19,822	0	33%
East Cheshire Trust	6,025	6,033	8	0%	2.0%	2.0%	2.5%	2.8%	3.0%	3.4%	3.8%	4.9%	2,823	3,211	47%	11,225	0	54%
Liverpool Heart & Chest	6,781	5,013	(1,768)	-26%	1.9%	2.3%	2.5%	2.6%	2.9%	2.9%	3.0%	4.5%	3,830	1,183	56%	10,644	0	47%
Liverpool University Hospitals	60,486	52,804	(7,682)	-13%	4.3%	4.4%	4.6%	5.0%	5.3%	5.2%	5.5%	8.3%	30,387	22,417	50%	114,600	(0)	46%
Liverpool Women's	3,397	4,384	987	29%	1.2%	1.6%	2.5%	3.8%	3.8%	3.5%	3.5%	3.2%	1,688	2,696	50%	5,904	0	74%
Mersey Care	17,311	17,311	0	0%	3.5%	3.4%	3.4%	3.4%	3.4%	3.3%	3.3%	3.5%	16,060	1,251	93%	25,967	0	67%
Mid Cheshire Hospitals	14,039	11,153	(2,886)	-21%	2.3%	2.5%	2.7%	3.0%	3.2%	3.3%	3.7%	5.0%	7,174	3,979	51%	22,437	0	50%
Mersey & West Lancs	26,670	28,537	1,867	7%	2.9%	3.2%	3.6%	3.8%	4.0%	4.2%	4.4%	4.6%	20,670	7,867	78%	47,965	2,800	63%
The Clatterbridge Centre	6,667	6,667	0	0%	3.3%	3.4%	3.3%	3.3%	3.3%	3.2%	3.2%	3.4%	3,586	3,081	54%	10,000	0	67%
The Walton Centre	5,666	5,666	0	0%	4.1%	4.3%	4.3%	4.3%	4.3%	4.2%	4.1%	4.5%	5,086	580	90%	8,558	0	66%
Warrington & Halton Hospitals	9,540	9,716	176	2%	1.7%	2.0%	2.5%	2.8%	3.0%	3.3%	3.6%	4.9%	7,249	2,467	76%	19,433	(0)	50%
Wirral Community	3,674	4,066	392	11%	2.4%	4.0%	4.1%	3.8%	3.9%	4.6%	5.5%	5.8%	928	3,138	25%	6,275	(0)	65%
Wirral University Hospitals	16,724	16,724	0	0%	3.1%	3.1%	2.7%	2.4%	4.3%	4.4%	4.5%	5.0%	11,677	5,047	70%	26,878	(0)	62%
TOTAL Providers	211,438	196,318	(15,120)	-7%	3.0%	3.3%	3.5%	3.5%	4.0%	4.0%	4.3%	5.5%	128,948	67,370	61%	370,509	2,799	53%
C&M ICB	46,357	38,993	(7,364)	-16%	0.6%	0.6%	0.6%	0.6%	0.6%	0.8%	0.8%	1.0%	38,993	0	84%	66,226	(6,010)	54%
TOTAL ICS System	257,795	235,311	(22,484)	-9%	3.7%	3.8%	3.9%	4.1%	4.2%	4.3%	4.5%	6.1%	167,941	67,370	65%	436,735	(3,211)	53%

Appendix 3B - System Efficiencies: M8 Risk and Development of CIP Plan

	Month 8 (end of Oct 25) assessment										% of CIP Opportunity / Unidentified	
	CIP RISK				CIP DEVELOPMENT					% of CIP High Risk %		
	Low £m	Medium £m	High £m	Total £m	Fully £m	In Progress £m	Opportunity £m	Unidentified £m	Total £m			
Alder Hey Children's	16.3	1.7	1.9	20.0	16.1	3.9	0.0	0.0	20.0	10%	0%	
Bridgewater Community	2.8	2.1	2.0	6.9	5.0	0.0	0.0	2.0	6.9	28%	28%	
Cheshire & Wirral Partnership	10.8	1.1	2.0	13.9	10.8	1.1	0.4	1.6	13.9	15%	15%	
Countess of Chester Hospitals	9.0	2.7	8.1	19.8	9.7	1.7	8.5	0.0	19.8	41%	43%	
East Cheshire Trust	6.8	1.4	3.0	11.2	3.3	5.6	2.3	0.0	11.2	27%	20%	
Liverpool Heart & Chest	5.6	3.3	1.8	10.6	3.4	4.7	2.5	0.0	10.6	17%	23%	
Liverpool University Hospitals	89.4	18.1	7.1	114.6	107.8	0.9	5.9	0.0	114.6	6%	5%	
Liverpool Women's	3.7	2.2	0.0	5.9	5.4	0.5	0.0	0.0	5.9	0%	0%	
Mersey Care	12.2	13.8	0.0	26.0	10.3	15.6	0.0	0.0	26.0	0%	0%	
Mid Cheshire Hospitals	19.1	1.0	2.3	22.4	21.8	0.5	0.1	0.0	22.4	10%	0%	
Mersey & West Lancs	40.8	6.6	0.6	48.0	40.9	6.4	0.6	0.0	48.0	1%	1%	
The Clatterbridge Centre	10.0	0.0	0.0	10.0	10.0	0.0	0.0	0.0	10.0	0%	0%	
The Walton Centre	6.4	2.2	0.0	8.6	1.4	7.1	0.0	0.0	8.6	0%	0%	
Warrington & Halton Hospitals	15.6	3.6	0.3	19.4	16.3	2.4	0.8	0.0	19.4	2%	4%	
Wirral Community	5.5	0.3	0.5	6.3	5.5	0.3	0.5	0.0	6.3	7%	7%	
Wirral University Hospitals	25.2	1.1	0.6	26.9	25.2	1.3	0.3	0.0	26.9	2%	1%	
C&M ICB	20.6	34.0	11.6	66.2	58.7	7.5	0.0	0.0	66.2	17%	0%	
Total	299.7	95.1	41.9	436.7	351.9	59.5	21.8	3.6	436.7	10%	6%	

Appendix 4: Provider Cash at Month 8

Org	Cash Balance			Operating Days Cash - Trend								External Cash Support*		BPPC % of bills paid in target	
	2023/24 M12 Closing Cash Balance	2024/25 M8 Closing Cash Balance	Movement	2023/24 M12	2024/25 M3	2024/25 M4	2024/25 M5	2024/25 M6	2024/25 M7	2024/25 M8	Trend	Received as at M8	FOT	2024/25 M8 By number	2024/25 M8 By Value
	£m	£m	£m	Days	Days	Days	Days	Days	Day	Day		£m	£m	%	%
Alder Hey Children's	78.3	52.1	(26.1)	63	52	47	52	50	43	46		0.0	0.0	93.4%	92.0%
Bridgewater Community	17.3	9.4	(7.9)	51	53	52	50	38	31	33		0.0	0.0	98.1%	98.4%
Cheshire & Wirral Partnership	28.1	30.7	2.6	27	32	33	31	39	41	40		0.0	0.0	95.9%	92.9%
Countess of Chester Hospitals	12.3	10.7	(1.6)	8	4	2	10	7	14	10		13.6	13.8	95.1%	95.7%
East Cheshire Trust	17.9	14.5	(3.3)	21	18	18	13	14	24	24		0.0	0.0	93.3%	92.0%
Liverpool Heart & Chest	43.2	43.5	0.3	59	63	65	68	71	58	66		0.0	0.0	97.2%	98.0%
Liverpool University Hospitals	40.6	21.9	(18.7)	9	10	5	1	4	9	6		25.0	25.0	76.0%	91.5%
Liverpool Women's	2.0	13.6	11.6	3	7	4	2	6	27	28		7.0	7.0	93.7%	95.3%
Mersey Care	72.9	63.1	(9.8)	29	27	26	36	38	28	32		0.0	0.0	95.5%	96.1%
Mid Cheshire Hospitals	16.4	33.3	16.8	11	13	13	18	25	31	27		19.7	19.7	94.3%	94.6%
Mersey & West Lancs	24.7	3.7	(20.9)	8	1	2	2	2	13	1		17.0	17.0	83.8%	91.8%
The Clatterbridge Centre	74.3	72.4	(1.9)	130	93	81	90	91	85	91		0.0	0.0	97.9%	99.1%
The Walton Centre	51.6	57.2	5.6	69	119	108	113	105	100	99		0.0	0.0	93.2%	94.3%
Warrington & Halton Hospitals	17.6	16.2	(1.4)	12	6	10	5	6	20	15		13.4	24.8	86.7%	91.3%
Wirral Community	12.7	8.5	(4.2)	33	45	41	49	55	28	31		0.0	0.0	92.3%	95.2%
Wirral University Hospitals	10.6	2.5	(8.1)	6	3	3	3	1	5	2		0.0	25.0	52.6%	73.1%
TOTAL Providers	520.6	453.5	(67.1)							16		95.7	132.3	89.9%	93.2%

Appendix 5: Provider BPPC at Month 8

Better Payment Practice Code (BPPC)	BPPC % of bills paid within 95% target															
	By Number								By Value							
	2023/24	2024/25	2024/25	2024/25	2024/25	2024/25	2024/25	Trend	2023/24	2024/25	2024/25	2024/25	2024/25	2024/25	2024/25	Trend
	M12	M3	M4	M5	M6	M7	M8		M12	M3	M4	M5	M6	M7	M8	
%																
Alder Hey Children's	94.0%	92.6%	93.0%	93.4%	93.0%	93.3%	93.4%		92.9%	91.4%	91.0%	91.3%	91.4%	91.9%	92.0%	
Bridgewater Community	96.2%	96.6%	97.2%	97.5%	97.8%	98.0%	98.1%		96.8%	97.3%	97.7%	98.0%	98.3%	98.3%	98.4%	
Cheshire & Wirral Partnership	97.7%	94.6%	95.4%	95.7%	96.0%	95.9%	95.9%		97.1%	93.2%	93.5%	94.1%	94.2%	92.3%	92.9%	
Countess of Chester Hospitals	86.3%	95.7%	95.8%	95.6%	95.3%	95.2%	95.1%		89.1%	95.7%	95.9%	95.5%	95.6%	95.4%	95.7%	
East Cheshire Trust	94.9%	94.0%	94.6%	92.1%	91.7%	93.1%	93.3%		95.4%	93.3%	93.9%	92.8%	92.8%	92.0%	92.0%	
Liverpool Heart & Chest	96.4%	97.0%	96.9%	97.1%	97.2%	97.1%	97.2%		97.0%	97.1%	97.2%	97.4%	97.6%	97.8%	98.0%	
Liverpool University Hospitals	82.1%	76.6%	76.1%	76.9%	75.6%	76.3%	76.0%		92.8%	91.3%	91.4%	91.8%	91.7%	91.6%	91.5%	
Liverpool Women's	91.1%	92.2%	92.5%	92.9%	92.8%	93.5%	93.7%		93.6%	95.1%	95.1%	93.9%	94.7%	94.9%	95.3%	
Mersey Care	95.2%	95.2%	95.3%	95.3%	95.2%	95.3%	95.5%		93.0%	96.3%	96.1%	96.2%	96.1%	96.1%	96.1%	
Mid Cheshire Hospitals	88.6%	93.2%	93.4%	93.9%	94.1%	94.4%	94.3%		92.8%	93.2%	93.7%	94.1%	94.1%	94.4%	94.6%	
Mersey & West Lancs	90.2%	83.8%	82.6%	82.5%	82.4%	83.2%	83.8%		92.6%	92.4%	93.2%	92.6%	92.1%	92.4%	91.8%	
The Clatterbridge Centre	97.6%	97.8%	98.0%	97.8%	97.9%	97.8%	97.9%		99.3%	98.9%	99.1%	99.1%	99.3%	99.2%	99.1%	
The Walton Centre	90.4%	93.5%	93.9%	93.8%	93.5%	93.4%	93.2%		92.5%	94.9%	94.8%	94.2%	94.2%	94.1%	94.3%	
Warrington & Halton Hospitals	91.5%	91.8%	87.4%	86.8%	88.0%	87.7%	86.7%		91.4%	91.2%	89.2%	90.3%	90.7%	90.0%	91.3%	
Wirral Community	91.6%	92.4%	92.1%	92.1%	92.5%	92.6%	92.3%		93.4%	93.4%	94.1%	94.2%	94.0%	94.8%	95.2%	
Wirral University Hospitals	92.3%	74.2%	60.3%	52.3%	47.1%	48.6%	52.6%		95.1%	87.0%	81.9%	76.7%	74.5%	71.8%	73.1%	
Average C&M Providers	92.3%	91.3%	90.3%	89.7%	89.4%	89.7%	89.9%		94.0%	93.9%	93.6%	93.3%	93.2%	92.9%	93.2%	

Appendix 6: Provider Capital Expenditure YTD and FOT vs ICS Allocation at Month 8

	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Plan Year Ending £'000	FOT Year Ending £'000	Variance Year Ending £'000	Spend YTD as % of FOT
						%	
Alder Hey Children'S NHS Foundation Trust	5,057	5,252	(195)	16,923	15,775	1,148	6.8%
Bridgewater Community Healthcare NHS Foundation Trust	3,263	1,251	2,012	4,467	4,460	7	0.2%
Cheshire And Wirral Partnership NHS Foundation Trust	5,695	4,130	1,565	7,866	6,366	1,500	19.1%
Countess Of Chester Hospital NHS Foundation Trust	59,152	41,307	17,845	77,750	78,755	(1,005)	-1.3%
East Cheshire NHS Trust	4,946	3,984	962	6,222	7,204	(982)	-15.8%
Liverpool Heart And Chest Hospital NHS Foundation Trust	3,992	3,614	378	7,811	7,811	-	0.0%
Liverpool University Hospitals NHS Foundation Trust	19,181	20,528	(1,347)	59,398	50,158	9,240	15.6%
Liverpool Women'S NHS Foundation Trust	4,276	2,319	1,957	5,035	5,035	-	0.0%
Mersey Care NHS Foundation Trust	15,385	8,626	6,759	36,254	34,503	1,751	4.8%
Mid Cheshire Hospitals NHS Foundation Trust	10,157	23,370	(13,213)	13,553	38,234	(24,681)	-182.1%
Mersey and West Lancashire Teaching Hospitals NHS Trust	16,970	8,653	8,317	28,256	28,256	-	0.0%
The Clatterbridge Cancer Centre NHS Foundation Trust	4,742	4,956	(214)	11,110	11,110	0	0.0%
The Walton Centre NHS Foundation Trust	3,714	2,933	781	6,890	8,390	(1,500)	-21.8%
Warrington And Halton Teaching Hospitals NHS Foundation Trust	5,994	5,011	983	9,470	9,470	-	0.0%
Wirral Community Health And Care NHS Foundation Trust	3,142	2,625	517	6,453	5,254	1,199	18.6%
Wirral University Teaching Hospital NHS Foundation Trust	7,499	6,445	1,054	12,870	14,823	(1,953)	-15.2%
Total Provider CDEL	173,165	145,004	28,162	310,328	325,604	(15,276)	-4.9%
ICS Capital allocation					325,604		
Variance to allocation					(0)		
Allocation met					Yes		

Meeting of the Board of NHS Cheshire and Merseyside

30 January 2025

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

Agenda Item No: ICB/01/25/08

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

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

Committee Chair	Erica Morriss
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Meeting date	17 December 2024 & 21 January 2025

Key escalation and discussion points from the Committee meeting

Alert

At its meeting in December 2024:

- **Strategic Priority Risk Review**
 FIRC aware that a BAF review is being carried out by Exec Team following MIAA report. The meeting noted the need to include the strategic financial risk over the 2-5 years, separate to, the in-year financial risk to ensure focus on the strategic changes required to deliver LT financial sustainability.
- **Strategic Priority Assurance - Digital – Population Health, Shared Care Record & Research and Innovation.**
 FIRC approved the following 4 recommendations subject to ratification of the overall 25/26 financial plan - (taking into consideration the planning priorities yet to be published).

 - approve a ring-fenced budget for the next 5 years
 - approve a simplified funding model
 - approved the procurement of the necessary services and support from April 2025
 - approve that the ICB should hold the key contracts associated with recommendation 3
- **24/25 Control Total Month 8 position**
 As of the 30th November 2024 (Month 8) the ICS is reporting a deficit of £229.4m (excluding deficit support) against a planned YTD deficit of £162.1m resulting in an adverse YTD variance of £67.3m.

 - New pressure of £3m arising from the WUTH cyber attack – mainly relating to loss of elective activity & costs of recovery.
 - deterioration in ICB run-rate across existing challenged budgets – CHC/MH packages and prescribing.

CIP delivery is behind plan with £235m delivered, compared to a plan of £258m. Of this, £67m is non-recurrent, contributing to deteriorating underlying position for the ICS as a whole.

Capital spend to date behind plan (Primary Capital 100% spent), Providers forecasting to achieve plan by year-end.

Cash position of the Providers is at £453.5m, of which £95.7m is External Cash support. BPPC levels are very low. The ICB has supported WUTH with a £8m cash advance to support them through December. Their January's cash

request has been accepted. But their cash position remains an ongoing risk, particularly in March.

- **24/25 Control Total Month 9 tabled position**

As of the 31st December 2024 (Month 9) the ICS is reporting a deficit of £242.2m (excluding deficit support) against a planned YTD deficit of £181m resulting in an adverse YTD variance of £61.1m.

- Some improvements to run-rate seen in MWL (delivery of savings earlier than planned) and LUHFT (also improved efficiency delivery ahead of plan)
- Some providers are flagging risks associated with Pay Award and reduced elective activity arising from the challenging start to the year from an urgent care perspective.

A simple mathematical forecast would indicate an out-turn close to £323m deficit. NHSE have indicated that their expectations are for the system to deliver a position closer to £200m deficit. We are working with Providers and utilising cap to revenue opportunities to bring us closer to this forecast position.

- **24/25 Recovery Sub - Comm. update M8**

YTD reporting £7.7m behind plan, forecasting to be £20.3m behind plan by year end. Reporting a deterioration compared to Month 7 in Medicines Management and AACC. Recovery Sub Comm review of future operating model submitted to Execs in Jan25. FIRC will be updated in Feb25.

At its meeting in January 2025:

- **Month 7 position**

As of 31st October 2024 (Month 7) the ICS is reporting a YTD deficit of £200.4m (excluding deficit support) against a planned YTD deficit of £149m resulting in an adverse YTD variance of £51.4m (1.1%).

The risk-adjusted deficit from I&I phase 1 of a £223m deficit was not accepted by NHSE. Current intelligence would indicate that this forecast could deteriorate further, due to pressures arising from the Pay Award, CIP achievement and delivery of high-risk transactions that are profiled in Month 12 (e.g. collaboration efficiencies and legal claim settlement).

Capital spend to date behind plan (Primary Capital 100% spent), Providers forecasting to achieve plan by year-end

Cash position has improved following the distribution of the deficit support, but some Trusts are managing very low levels of cash. WUTH in particular has a very low BPPC. The ICB is reviewing cash available to support WUTH through December, while WUTH are exploring opportunities with neighbouring providers to support.

- **Month 8 tabled position**

As of the 30th November 2024 (Month 8) the ICS is reporting a deficit of £229.4m (excluding deficit support) against a planned YTD deficit of £162.1m resulting in an adverse YTD variance of £67.3m.

- New pressure of £3m arising from the WUTH cyber attack – mainly relating to loss of elective activity & costs of recovery.
- deterioration in ICB run-rate across existing challenged budgets – CHC/MH packages and prescribing.



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A simple mathematical forecast would indicate an out-turn of £350m deficit. There are a number of transactions forecast in month 12 – benefits from collaboration, Legal cases and back-ended CIP. Delivering the risk adjusted forecast of £223m will be challenging to deliver.

Advise

At its meeting in December 2024:

- **I&I update phase 2**
- **ICB Provider Assurance**
The weekly FICC, administered by PwC, continued until the end of December 2024. It has now been replaced by CEO/DoF meetings with all C&M NHS Providers in early Jan. A Balanced Scorecard has been developed taking into account finance, WTE, balance sheet and productivity metrics. This scorecard drives the agenda, which focuses on delivery of the year-end financial position, and the improvements required for 25/26.
- **Specific Trust/Issue Focus**
 - Mid Cheshire – Phase 2 support was focussed on Project Management support and delivery of CIP. This has now completed. ICB is awaiting the final report summarising output of work and further opportunities. Mid-Cheshire are deploying PwC to support project management in 25/26.
 - LAASP – Case for change out for review and due to be completed by end of January 2025
 - LUHFT – work is two-thirds complete. Initial assessment indicates that there is considerable opportunity for improvement. Embedding traction and good practice in a large and complex organisation is a key challenge.
 - Warrington & Halton – Theatre productivity analysis report is complete and currently being reviewed. Data quality and provision needs to be improved, which would provide more timely direction to Trust management. The review of the opportunities for co-ordination between the acute and community trust has not identified any significant opportunities for delivery in year, but considerable opportunity in the future.
- **25/26 Planning**
No guidance received as yet. Update formed part of Board Development session
- **Strategic Estates Governance**
update on progress provided. Final Governance document to be presented to February FIRC for consideration and recommendation to Board.
- **CSU Contract**
Approval given for the renewal of several corporate services functions with NHS CSU: Business Intelligence, Complaints/Incident reporting, Subject Access Requests, Employment services, HR & OD, Individual Funding Requests, GP IT, Procurement, Referral Management, H&S and Data



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- **Recent updates**

Providers aware of increased discussion over Pay uplifts for Bands 4-6.
ERF: Very recently advised that there will be a hard ceiling of ERF funding based on the ICB's forecast at Month 9. Initial view is that this will be sufficient to cover expected levels of elective activity.

At its meeting in January 2025:

- **M7 Recovery update**

Efficiency target £122m, YTD reporting £9.4m behind plan, forecasting a variance of £35.4m to plan.

- Commenced planning for 25/26
- Decommissioning Panel to be operational from January 2025 and analysis now been undertaken in collaboration with CMAST.
- Reducing unwarranted variation programme has commenced work on the Evidence Based Initiatives element of the programme, focussing on category 2 interventions.

- **I&I phase 2 update**

- Weekly FICC sessions continue, rotating focus between Pay/WTE and Efficiencies & non-pay. Attended by 4 high risk Trusts
Reviewing efficiency and data collection for January onwards.
- ICB-facing version of FICC deemed unlikely to add value at this time due to time lag in data availability and presence of other governance forums.
 - LUHFT – Medical Staffing Review, Establishment Review & Support, Productivity Support
 - LAASP – Case for Change, Financial Framework, Financial sustainability plan, commercial opportunities, CIP enhancement opportunities
 - W&H – UEC Actions, Productivity actions, Pay and non-pay grip and control, In-year integration assurance
 - WUTH – Workforce and Productivity
 - MCT – Variable Pay/Admin & Digital, DMO support. H2 stocktake, Financial Training
 - ICB – All Age Continuing Care- recruitment planning, data development QIPP enhancement, strategic commissioning, Place analysis.

Assure

At its meeting in January 2025:

FIRC have concurred with the Executive recommendation to stand down AACC – Care Assessment Panel and that formal agreement of the replacement SORD arrangements will be agreed by Audit Comm in due course

Committee risk management

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

BAF P7 is Scored at 20 critical – this was agreed.

Noted changes to Place Finance risks to better reflect the overall ICS financial Risk. Some discussion about the need for separate risks to clearly identify the ICB finance risk as separate from the ICS financial risk.

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 for 2024/5	24/25 Financial Plan report for both ICB and Specialised Commissioning
Delivery of the Finance Efficiency & Value Programme	Month 7, 8 and 9 Finance report
Development and delivery of the Capital Plans.	Month 7, 8 and 9 Finance report
Development of System Estates Plans to deliver a programme to review and rationalise our corporate estates.	Update provided at January meeting – Estates Strategy to come to February 2025 meeting for approval.

Meeting of the Board of NHS Cheshire and Merseyside

30 January 2025

Integrated Performance Report

Agenda Item No: ICB/01/25/09

Responsible Director: Anthony Middleton
Director of Performance and Planning



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Integrated Performance Report

1. Purpose of the Report

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

2. Executive Summary

- 2.1 The integrated performance report for January 2025, see appendix one, provides an overview of key metrics drawn from the 2024/25 Operational plans, specifically covering Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance.
- 2.2 For metrics that are not performing to plan, the integrated performance report provides further analysis of the issues, actions and risks to delivery in section 5 of the integrated performance report.

3. Ask of the Board and Recommendations

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

4. Reasons for Recommendations

- 4.1 The report is sent for assurance.

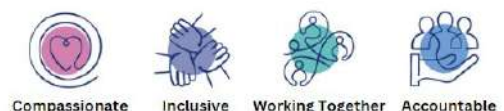
5. Background

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

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

Objective One: Tackling Health Inequalities in access, outcomes and experience

Reviewing the quality and performance of services, providers and place enables the ICB to set system plans that support improvement against health inequalities.



Objective Two: Improving Population Health and Healthcare

Monitoring and management of quality and performance allows the ICB to identify where improvements have been made and address areas where further improvement is required.

Objective Three: Enhancing Productivity and Value for Money

The report supports the ICB to triangulate key aspects of service delivery, finance and workforce to improve productivity and ensure value for money.

Objective Four: Helping to support broader social and economic development

The report does not directly address this objective.

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

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

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety

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

Theme Two: Integration

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

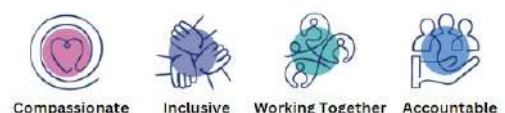
Theme Three: Leadership

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

9. Risks

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

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



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

10. Finance

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

11. Communication and Engagement

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

12. Equality, Diversity and Inclusion

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

13. Climate Change / Sustainability

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

14. Next Steps and Responsible Person to take forward

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

15. Officer contact details for more information

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

16. Appendices

Appendix One: Integrated Quality and Performance report

Integrated Performance Report

30th January 2025



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Integrated Quality & Performance Report – Guidance:



Cheshire and Merseyside

Provider Acronyms:

ACUTE TRUSTS

COCH COUNTESS OF CHESTER HOSPITAL NHS FT

ECT EAST CHESHIRE NHS TRUST

MCHT MID CHESHIRE HOSPITALS NHS FT

LUFT LIVERPOOL UNIVERSITY HOSPITALS NHS FT

MWL MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST

WHH WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT

WUTH WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT

SPECIALIST TRUSTS

AHCH ALDER HEY CHILDREN'S HOSPITAL NHS FT

LHCH LIVERPOOL HEART AND CHEST HOSPITAL NHS FT

LWH LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

TCCC THE CLATTERBRIDGE CANCER CENTRE NHS FT

TWC THE WALTON CENTRE NHS FT

COMMUNITY AND MENTAL HEALTH TRUSTS

BCHC BRIDGEWATER COMMUNITY HEALTHCARE NHS FT

WCHC WIRRAL COMMUNITY HEALTH AND CARE NHS FT

MCFT MERSEY CARE NHS FT

CWP CHESHIRE AND WIRRAL PARTNERSHIP NHS FT

KEY SYSTEM PARTNERS

NWAS NORTH WEST AMBULANCE SERVICE NHS TRUST

CMCA CHESHIRE AND MERSEYSIDE CANCER ALLIANCE

OTHER

OOA OUT OF AREA AND OTHER PROVIDERS

Key:

Data formatting

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

C&M National Ranking against the 42 ICBs

$\leq 11^{\text{th}}$	C&M in top quartile nationally
12^{th} to 31^{st}	C&M in interquartile range nationally
$\geq 32^{\text{nd}}$	C&M in bottom quartile nationally
-	Ranking not appropriate/applied nationally

C&M National Ranking against the 22 Cancer Alliances

$\leq 5^{\text{th}}$	C&M in top quartile nationally
6^{th} to 17^{th}	C&M in interquartile range nationally
$\geq 18^{\text{th}}$	C&M in bottom quartile nationally
-	Ranking not appropriate/applied nationally

Notes on interpreting the data

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

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

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

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

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

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

Integrated Quality & Performance Report – Interpreting SPC Charts:

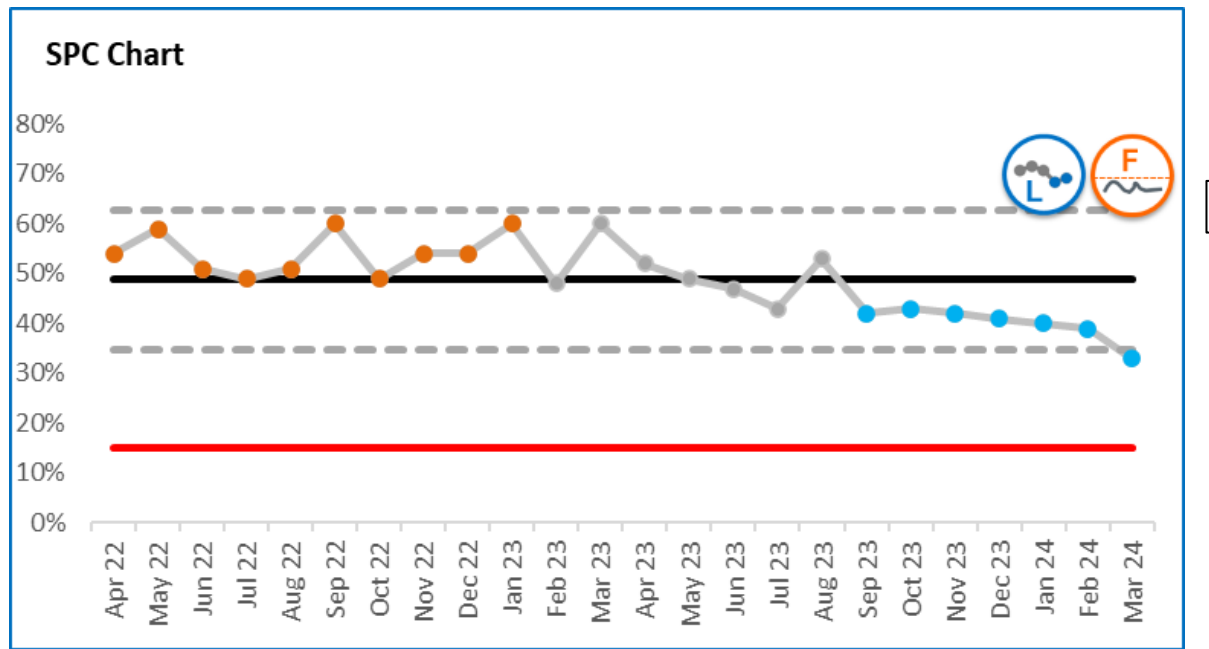
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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

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

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

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



- UPL
- Average
- LPL
- Target

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

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

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

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

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

Variation / performance icons			
Icon	Technical description	What does this mean?	What should we do?
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is currently not changing significantly . It shows the level of natural variation you can expect from the process or system itself.	Consider if the level/range of variation is acceptable. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	Something's going on! Something, a one-off or a continued trend or shift of numbers in the wrong direction	Investigate to find out what is happening or has happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	Something good is happening! Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening or has happened. Celebrate the improvement or success. Is there learning that can be shared to other areas?
Assurance icons			
Icon	Technical description	What does this mean?	What should we do?
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies within those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is the target will be achieved or missed at random.	Consider whether this is acceptable and, if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies outside of those limits in the wrong direction then you know the target cannot be achieved.	You need to change something in the system or process if you want to meet the target. The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies outside of those limits in the right direction then you know the target can consistently be achieved.	Celebrate the achievement. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

1. ICB Aggregate Position

Category	Metric	Latest period	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Local Trajectory	National Target	Region value	National value	Latest Rank
Urgent care	4-hour A&E waiting time (% waiting less than 4 hours)	Dec-24	69.4%	68.9%	68.1%	71.9%	72.1%	71.1%	72.7%	74.4%	74.3%	72.9%	72.3%	72.4%	71.4%	77.2%	78% by Year end	69.5%	71.1%	20/42
	Ambulance category 2 mean response time	Dec-24	01:04:31	00:49:45	00:43:30	00:29:31	00:24:49	00:33:02	00:34:47	00:37:59	00:24:58	00:38:08	00:56:23	00:52:34	01:06:45	-	00:30:00	00:42:21	00:47:26	-
	A&E 12 hour waits from arrival	Dec-24	16.1%	18.5%	16.7%	15.7%	15.8%	16.8%	15.8%	15.6%	15.5%	16.6%	17.0%	15.7%	18.3%	-	-	15.4%	12.0%	38/42
	Adult G&A bed occupancy	Dec-24	95.3%	96.6%	95.9%	96.0%	95.3%	95.8%	95.9%	95.5%	94.9%	95.6%	96.3%	96.5%	96.0%	94.3%	92.0%	95.1%	95.4%	29/42
	21+ day Length of Stay	Dec-24	1,368	1,386	1,396	1,413	1,303	1,379	1,364	1,321	1,349	1,371	1,362	1,326	1,474	0	-	-	-	-
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Dec-24	20.8%	21.0%	19.8%	20.1%	21.6%	21.8%	21.3%	21.5%	19.9%	19.6%	20.4%	21.7%	19.5%	13.2%	*	14.5%	13.5%	39/42
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Nov-24	5,227	4,732	3,736	2,195	2,324	2,331	2,285	2,098	1,972	985	1,091	1,093		0	-	2,139	22,903	-
	Number of 52+ week RTT waits, of which children under 18 years.	Dec-24			1,497	1,446	1,471	1,505	1,542	1,493	1,295	1,029	1,063	886	897	1,381	-	n/a	n/a	-
	Total incomplete Referral to Treatment (RTT) pathways	Nov-24	372,974	369,750	371,542	365,756	367,759	369,179	368,967	370,607	372,357	369,065	367,350	366,053		374,565	-	1,061,492	7,573,212	-
	Patients waiting more than 6 weeks for a diagnostic test	Nov-24	17.2%	16.2%	10.7%	10.0%	10.2%	10.0%	10.1%	9.0%	10.1%	8.8%	7.2%	6.9%		10.0%	10.0%	17.4%	19.9%	2/42
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	Nov-24	71.8%	67.2%	69.0%	75.4%	70.9%	71.8%	72.1%	75.9%	74.6%	73.0%	73.8%	75.9%		72.0%	85.0%	73.0%	69.4%	11/42
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Nov-24	95.0%	91.9%	93.2%	92.4%	91.8%	95.4%	94.5%	94.8%	94.3%	93.3%	94.6%	94.2%		96.0%	96.0%	93.6%	91.0%	10/42
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Nov-24	70.2%	67.2%	74.8%	76.0%	71.3%	71.4%	73.8%	74.1%	73.2%	71.4%	73.3%	75.4%		75.0%	77% by Year end	77.8%	77.4%	29/42
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028*. (rolling 12 months)	Sep-24	59.0%	59.0%	59.1%	59.1%	59.0%	59.0%	59.1%	58.9%	59.0%	60.0%				70.0%	75% by 2028	57.6%	58.7%	17/42
Mental Health	Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Sep-24					22,530	22,660	22,670	22,885	22,865	22,995				20444		55845	517749	-
	Referrals on the Early Intervention in Psychosis (EIP) pathway seen in 2 weeks	Oct 24 YTD	75%	75%	76%	78%	78%	78%	78%	76%	75%	73%	75%		60.0%	60.0%	72.0%	72.3%	20/42	
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	Q2 24/25	45.0%		57.8%		55.0%		52.0%							-	60.0%	55.0%	57.0%	34/42
	Dementia Diagnosis Rate	Nov-24	66.4%	66.3%	66.8%	67.0%	67.0%	67.2%	67.4%	67.7%	67.6%	67.4%	67.6%	67.4%		66.7%	66.7%	70.6%	65.8%	17/42
	CYP Eating Disorders Routine (NEW)	Oct-24	99.0%	99.0%	95.0%	94.0%	79.0%	79.0%	71.0%	79.0%	77.0%	79.0%	84.0%		95.0%	95.0%	76.0%	77.3%	18/40	
	CYP Eating Disorders Urgent (NEW)	Oct-24	-	100.0%	100.0%	100.0%	42.0%	-	27.0%	57.0%	73.0%	85.0%	90.0%		95.0%	95.0%	81.0%	81.2%	12/25	
	CYP 1+ Contacts (NEW) - % LTP trajectory achieved	Oct-24	-	-	-	-	93.0%	92.0%	92.0%	93.0%	91.0%	92.0%	92.0%		100.0%	100.0%	108.0%	96.0%	21/42	
	Perinatal Access (NEW) - % LTP trajectory achieved	Oct-24	-	-	-	-	118.0%	119.0%	120.0%	122.0%	123.0%	125.0%	127.0%		100.0%	100.0%	105.0%	94.0%	5/42	
	Talking Therapies completing a course of treatment (NEW) - % of LTP trajectory	Oct-24	-	-	-	-	100.0%	97.0%	79.0%	98.0%	90.0%	93.1%	105.0%		100.0%	100.0%	94.0%	102.0%	23/42	
	Talking Therapies Reliable Recovery (NEW)	Oct-24	40.0%	47.0%	45.0%	48.0%	48.0%	46.0%	41.0%	47.0%	46.0%	46.0%	48.0%		48.0%	48.0%	46.0%	47.1%	19/42	
	Talking Therapies Reliable Improvement (NEW)	Oct-24	63.0%	67.0%	66.0%	66.0%	66.0%	67.0%	50.0%	66.0%	65.0%	65.0%	66.0%		67.0%	67.0%	65.0%	67.4%	30/42	
Note/s	* no national target for 2024/25 ** Wirral data missing for 30 November so 28 November used instead																			

1. ICB Aggregate Position

Category	Metric	Latest period	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Local Trajectory	National Target	Region value	National value	Latest Rank	
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Nov-24	110	100	100	100	95	95	100	100	95	90	85	80		≤ 60	-	265	1,830	25/42	
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Oct 24 YTD	45.4%	61.1%	76.0%	91.4%	3.1%	7.3%	12.0%	17.7%	23.9%	30.2%	38.2%			32.9%	75% by Year end	40.0%	37.9%	16/42	
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Oct-24	83%	80.0%	82.9%	80.0%	84%	87%	85%	84%	86%	85%	86%			70.0%	70.0%	89.0%	84.0%	18/42	
	Virtual Wards Utilisation (NEW)	Nov-24	45%	63.6%	48.4%	56.5%	41%	39%	70%	67%	62%	74.6%	93.20%	75.20%		80.0%	80.0%	66.7%	78.2%	5/42	
	Community Services Waiting List (Adults) (NEW)	Oct-24	42,927	42,980	40,486	45,682	48,213	53,285	49,459	54,375	54,021	54,830	48,815					117,362	828,530	-	
	Community services Waiting List (CYP) (NEW)	Oct-24	19,243	19,471	19,897	20,826	21,954	24,712	25,209	25,378	24,426	23,542	21,747					47,077	272,718	-	
	Community Services – Adults waiting over 52 weeks (NEW)	Oct-24	422	284	265	274	289	308	329	359	382	433	435			133		1,061	13,142	-	
Primary Care	Units of dental activity delivered as a proportion of all units of dental activity contracted	Nov-24	73.0%	80.0%	90.0%	95.0%	81.0%	81.0%	80.0%	79.0%	77.0%	82.0%	82.0%	83.0%		100.0%	100.0%	89.0%	84.0%	26/42	
	Number of unique patients seen by an NHS Dentist – Adults (24 month)	Nov-24	920,720	921,867	923,844	924,609	926,008	926,012	926,430	928,591	928,716	929,187	929,958	930,608			986,184		2,630,985	8,189,784	-
	Number of unique patients seen by an NHS Dentist – Children (12 month)	Nov-24	316,550	317,743	319,483	320,222	322,008	323,306	323,089	325,212	325,733	326,939	327,934	328,920			327,915		1,005,004	7,044,736	-
	Number of General Practice appointments delivered against baseline (corresponding month same period last year)	Nov-24	94.3%	106.8%	109.2%	92.8%	122.2%	106.9%	94.0%	109.0%	94.8%	93.7%	111.6%	97.6%			-	-	98.2%	100.0%	-
	Percentage of appointments made with General Practice seen within two weeks	Sep-24	90.8%	91.0%	90.6%	90.1%	88.9%	89.7%	89.5%	89.8%	90.1%	90.0%					85.0%	85.0%	88.7%	88.3%	13/42
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Jun-24	7.36%	7.33%	7.27%	7.19%	7.22%	7.17%	7.12%								10.0%	10.0%	-	7.68%	-
	Total volume of antibiotic prescribing in primary care	Jun-24	1.040	1.036	1.040	1.033	1.04	1.04	1.04								0.871	0.871	-	0.95	-
Integrated care - BCF metrics	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (average of place rates)***	Q2 24/25	262.5	262.8			244.4			222.0							-	-	219.1	176.8	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Oct-24	92.4%	92.8%	92.7%	93.4%	93.1%	93.4%	93.3%	93.0%	93.3%	93.3%	93.2%				-	-	92.3%	93.0%	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (average of place rates)***	Q2 24/25	607.0	531.5			535.3			526.1							-	-	478.0	452.2	-
Note/s	* no national target for 2024/25 *** Awaiting clarification from NHSE re: metric criteria. Plans are no longer comparable to actuals largely due to implementation of SDEC (Type 5) in year but also revisions to National criteria which systems need time to adopt and validate.																				

1. ICB Aggregate Position

Category	Metric	Latest period	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Local Trajectory	National Target	Region value	National value	Latest Rank	
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q1 24/25	65.89%	69.58%			65.82%										77.0%	80.0%	66.54%	66.9%	29/42
	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with lipid lowering therapies (NEW)	Q1 24/25	60.8%	61.9%			62.2%											65.0%	63.1%	62.29%	19/42
	Smoking at Time of Delivery (NEW)	Q2 24/25					7.3%			6.8%								<6%	6.8%	5.60%	30/42
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.	Dec-24	14.2%	14.2%	14.1%	13.9%	13.9%	13.8%	13.7%	13.6%	13.7%	13.7%	13.6%	13.6%	13.5%		12.0%	12.0%	-	12.7%^	-
Continuing Healthcare	Standard Referrals completed within 28 days	Q2 24/25	63.10%	62.40%			71.70%			64.70%							>80%	>80%	76.2%	72.4%	31/42
	% DST's (Decision Support Tool) completed that were in Hospital	Q2 24/25	0.00%	0.00%			0.00%			0.00%							<15%		0.2%	0.1%	1/42
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q2 24/25	24.48	25.33			28.75			29.15							<18		28.44	18.06	36/42
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q2 24/25	46.37	47.04			51.69			53.36							34.0		47.90	34.12	39/42
Maternity	HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks)	Q2 24/25	1.0	1.2			0.7			1.1							2.5	2.5	1.2		
	Still birth per 1,000 (rolling 12 months)	Aug-24	3.00	3.00	2.67	2.95	2.78	2.58	2.83	2.71	2.45						-	-	-	-	-
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation (Healthcare associated)	12 months to Oct 24	575	578	582	608	636	655	655	694	710	726	738				439	439	2167	11530	-
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Oct 24	778	797	788	812	816	823	810	813	813	817	829				518	518	2257	14527	-
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation #	Jul-24	1.017	1.004	1.006	1.001	0.998	0.993	0.999	0.991							0.887 to 1.127 *		-	1.000	-
	Never Events	Nov-24	3	1	1	3	4	2	2	1	1	1	0	3			0	0	-	-	-
Workforce / HR (ICS total)	Staff in post	Nov-24	72,993	73,069	73,344	73,267	73,078	73,011	72,945	72,909	73,039	73,548	73,910	74,068			71,994	-	198,623	-	-
	Bank	Nov-24	5,246	5,739	5,881	6,086	5,230	5,262	4,833	5,339	5,255	5,122	5,084	4,868			3,246	-	16,424	-	-
	Agency	Nov-24	1,245	1,257	1,187	1,279	1,209	1,088	1,072	1,104	1,009	932	1,009	886			980.8	-	4,206	-	-
	Turnover	Sep-24	11.4%	11.2%	11.1%	11.2%	11.3%	11.2%	11.3%	11.0%	11.0%	10.9%					13.0%	-	12.3%	-	-
	Sickness	Sep-24	5.5%	5.5%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%					6.2%	-	5.9%	5.04%	37/42
Note/s	<p>* 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.</p> <p>^ 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%</p> <p># Banding changed Aug 23 to reflect SOF bandings for providers. Green = no providers higher than expected, Amber = 1-2 providers higher than expected, Red = more than 2 providers higher than expected</p> <p>** -From December 2023 this metric is now available at ICB level, previously this was only reported at Cancer Alliance level. historical data has been updated</p>																				

2. ICB Aggregate Financial Position

ICB Overall Financial Position:

Category	Metric	Latest period	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Plan (£m)	Dir. Of Travel	FOT (£m) Plan	FOT (£m) Current	FOT (£m) Variance	
Finance	Financial position £m (ICS) ACTUAL	Aug-24	-80.8	-72.2	-79.8	-61.5	-98.7	-	-68.8	-101.0	-138.0	-166.9	-108.5	-112.9	-129.5	-62.1	↘	0.0	0.0	0.0	
	Financial position £ms (ICS) VARIANCE	Aug-24	-42.2	-40.8	-57.8	-50.5	-98.7	-	-19.1	-16.5	-38.5	-48.5	-48.8	-51.4	-67.4		↘				
	Efficiencies £ms (ICS) ACTUAL	Aug-24	227.0	246.4	302.7	334.4	388.6	-	41.9	64.7	92.3	119.9	156.4	192.9	235.3	257.8	↗	439.9	436.7	-3.2	
	Efficiencies £ms (ICS) VARIANCE	Aug-24	-14.0	-30.7	56.3	-16.8	-0.1	-	-15.2	-13.1	-20.2	-26.6	-25.0	-26.7	-22.5		↗				
	Capital £ms (ICS) ACTUAL	Aug-24	110.8	133.7	115.3	153.6	267.3	-	N/A	39.5	65.6	81.8	97.1	121.7	145.0	173.2			310.3	325.6	-15.3
	Capital £ms (ICS) VARIANCE	Aug-24	2.8	7.1	49.7	51.8	1.1	-	N/A	3.9	11.3	13.6	26.8	28.3	28.2						

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

Category	Metric	Latest period	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Vs Target expenditure (Current)	Vs Target expenditure (Previous)	Dir. Of Travel
Finance	Mental Health Investment Standard met/not met (MHIS)	Jul-24	Yes	Yes	Yes	Yes	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	↔
	BCF achievement (Places achieving expenditure target)	Jul-24	9/9	9/9	9/9	9/9	9/9	9/9	-	9/9	9/9	9/9	9/9	9/9	9/10	9/9	9/9	↔

3. Provider / Trust Aggregate Position

Category	Metric	Latest period	Providers																	ICB*
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Urgent care	4-hour A&E waiting time % waiting less than 4 hours)	Dec-24	55.5%	49.8%	54.5%	73.8%	67.5%	73.1%	77.0%	88.3%	-	89.2%	-	-	-	-	-	-	-	71.4%
	A&E 12 hour waits from arrival	Dec-24	26.6%	17.0%	17.7%	25.0%	23.6%	18.6%	19.0%	0.2%	-	0.0%	-	-	-	-	-	-	-	18.3%
	Adult G&A bed occupancy	Dec-24	97.9%	95.1%	91.7%	94.2%	95.4%	96.4%	98.1%	-	78.3%	58.1%	86.4%	85.9%					-	96.0%
	21+ day Length of Stay (ave per day)	Dec-24	114.2	38.9	123.8	170.5	122.6	463.5	253.8	1.4	13.4	0.0	27.6	26.4					-	1,474
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Dec-24	17.5%	10.1%	14.9%	16.3%	21.5%	24.3%	18.9%								-	19.5%		
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Nov-24	202	23	289	134	100	179	102	9	4	4	0	0			1	-	46	1,093
	Number of 52+ week RTT waits, of which children under 18 years.	Dec-24	166	25	145	135	49	33	97	245	0	0	0	2						897
	Total incomplete Referral to Treatment (RTT) pathways	Nov-24	34,389	12,758	38,827	48,018	34,118	70,335	80,378	22,171	5,805	16,334	1,153	15,952			61	-	-	366,053
	Patients waiting more than 6 weeks for a diagnostic test	Nov-24	7.8%	7.6%	3.3%	4.1%	11.9%	3.3%	3.0%	3.1%	8.9%	6.3%	0.0%	0.2%	38.6%	0.0%	-	-	-	6.9%
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Nov-24	82.5%	68.7%	68.7%	81.2%	72.1%	73.9%	80.1%	100.0%	85.3%	45.2%	85.5%	100.0%	79.2%				-	75.9%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Nov-24	91.9%	100.0%	85.9%	88.5%	98.6%	91.5%	91.7%	100.0%	100.0%	75.7%	96.8%	100.0%	100.0%				-	94.2%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Nov-24	81.9%	78.1%	68.8%	78.8%	74.5%	73.5%	75.0%		66.7%	72.9%	92.9%	100.0%	82.0%				-	75.4%
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Q4 2023/24	66.5%	66.7%	59.6%	59.0%	51.7%	72.3%	62.5%	-	48.1%	85.2%	39.2%	-	100.0%	-				58.9%
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 ** Indicates that provider did not meet to DQ criteria and is excluded from the analysis # Value suppressed due to small numbers																			

3. Provider / Trust Aggregate Position

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Oct-24			Mental Health service providers only												74.0%	80.0%	-	75.0%
	CYP Eating Disorders Routine (NEW)	Oct-24							67%							92.0%	99.0%		84.0%	
	CYP Eating Disorders Urgent (NEW)	Oct-24							93%							-	80%		90.0%	
	CYP 1+ Contacts (NEW) - % LTP trajectory achieved	Oct-24	Just number available/ no target																92.0%	
	Perinatal Access (NEW) - % LTP trajectory achieved	Oct-24	Just number available/ no target																127.0%	
	Talking Therapies completing a course of treatment (NEW) - % of LTP trajectory	Oct-24	Just number available/ no target																105.0%	
	Talking Therapies Reliable Recovery (NEW)	Oct-24															47.0%			48.0%
	Talking Therapies Reliable Improvement (NEW)	Oct-24															63.0%			66.0%
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Oct-24	81.0%	90.0%	89%	Community Service Providers only								-	87.0%	88.0%	-	80%	86.0%	
	Virtual Wards Utilisation (NEW)	Nov-24	122.9%	115.0%	104.1%		106.3%	121.4%	95.8%	231.3%										75.2%
	Community Services Waiting List (Adults) (NEW)	Oct-24	0	4,448	4,544	481	-	-	401	0	120	-	-	-	3,145	0	19,055	3,475	13,146	48,815
	Community services Waiting List (CYP) (NEW)	Oct-24	1,201	658	1,404	4,983	-	-	855	5,580	0	-	-	-	3,708	1,371	619	0	1,368	21,747
	Community Services – Adults waiting over 52 weeks (NEW)	Oct-24	0	2	5	0	-	-	0	0	17	-	-	-	18	0	9	152	232	435
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Indicates that provider did not meet to DQ criteria and is excluded from the analysis # Value suppressed due to small numbers																			

3. Provider / Trust Aggregate Position

Category	Metric	Latest period	Providers																	ICB *		
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB			
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP				
Health Inequalities & Improvement	Smoking at Time of Delivery (NEW) not available at trust level																					
Maternity	HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks)	24/25 Q2	0.0	0.0	0.0	4.0	2.9		0.0				1.1								1.1	
	Still birth per 1,000 (rolling 12 months)	Aug-24	2.10	1.72	3.57	2.43	2.85	-	1.60	-	-	2.78	-	-							2.45	
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation (Healthcare Associated)	12 months to Oct 24	(89 vs 56)	(19 vs 6)	(53 vs 31)	(140 vs 71)	(94 vs 36)	(194 vs 133)	(113 vs 85)	(12 vs 0)	(4 vs 2)	(1 vs 0)	(10 vs 13)	(9 vs 6)							738	
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Oct 24	(66 vs 35)	(45 vs 27)	(49 vs 24)	(98 vs 53)	(97 vs 54)	(258 vs 165)	(166 vs 121)	(10 vs 8)	(4 vs 6)	(6 vs 5)	(21 vs 10)	(9 vs 10)							829	
	Summary Hospital-level Mortality Rate (SHM) - Deaths associated with hospitalisation #	Jul-24	0.9444	1.2248	0.9071	0.9458	0.9971	0.9591	1.0673													0.991
	Never Events (rolling 12 month total)	12 Months to Nov 24	1	0	0	1	3	2	3	2	0	3	0	4	0	0	0	0	0	2***	21	
Workforce / HR (Trust Figures)	Staff in post	Nov-24	4,507	2,399	4,963	5,918	4,247	14,065	9,650	4,234	1,837	1,712	1,898	1,513	1,430	1,521	10,407	3,768	-	74,068		
	Bank	Nov-24	311	195	403	336	374	959	741	170	60	64	16	98	24	44	875	197	-	4,868		
	Agency	Nov-24	24	48	89	47	37	94	230	13	6	8	12	4	17	17	192	49	-	886		
	Turnover	Sep-24	11.7%	10.6%	9.4%	9.1%	10.2%	10.2%	10.1%	10.1%	13.0%	11.1%	11.1%	12.1%	10.0%	10.5%	13.5%	13.2%	-	10.9%		
	Sickness (via Ops Plan Monitoring Dashboard)	Sep-24	5.7%	5.7%	5.0%	6.1%	5.6%	6.2%	4.0%	5.6%	5.1%	6.0%	4.7%	5.6%	5.9%	6.5%	7.7%	6.4%	-	5.6%		
Finance	Overall Financial position Variance (£m)	Nov-24	-6.69	-0.30	-2.13	-10.96	-1.50	-5.74	2.94	-0.65	-0.44	0.64	0.00	0.47	-2.53	0.00	0.00	0.21	-40.70	-67.37		
	Efficiencies (Variance)	Nov-24	-4.86	0.01	-2.89	0.00	0.18	-7.68	1.87	0.54	-1.77	0.99	0.00	0.00	-1.06	0.39	0.00	-0.84	-7.40	-22.52		
	Capital (Variance)	Nov-24	17.85	0.96	-13.21	1.05	0.98	-1.35	8.32	-0.19	0.38	1.96	-0.21	0.78	2.01	0.52	6.76	1.57	0.00	28.16		
Note/s	<p>* 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</p> <p>** The SHM1 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.</p> <p>*** Independent Providers / Other providers 1 at Spire Murrayfield, 1 at Spa Medica Wirral</p> <p># Banding changed Aug 23 to reflect SOF rating by NHSE. 'As expected' rating is RAG rated Green, 'Higher than expected' is RAG rated Red.</p>																					

4. Place Aggregate Position

Category	Metric	Latest period	Sub ICB Place									ICB *	Local Trajectory	National Target	
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton				S/port & Formby
Urgent Care	4-hour A&E waiting time % waiting less than 4 hours)	Dec-24	52.7%	55.0%	41.7%	52.4%	71.3%	57.3%	73.0%	65.9%	62.4%	71.4%	77.2%	78% by Year end	
	Ambulance category 2 mean response time	Dec-24	00:55:20		01:13:16	01:06:26	01:10:26	01:11:43	01:09:20	01:13:41	01:13:22	01:06:45		00:30:00	
	A&E 12 hour waits from arrival	Dec-24	17.4%	22.8%	21.2%	21.5%	14.0%	21.4%	16.0%	23.9%	18.0%	18.3%	-	-	
Planned Care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Nov-24	529		165	78	123	35	45	63	55	1,093	0	-	
	Total incomplete Referral to Treatment (RTT) pathways	Nov-24	106,790		52,583	29,225	61,508	30,564	24,828	22,043	38,512	366,053	374,565	-	
	Patients waiting more than 6 weeks for a diagnostic test	Nov-24	7.9%		8.9%	8.1%	3.8%	5.8%	3.4%	14.7%	5.0%	6.9%	10.0%	10%	
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Nov-24	68.7%	77.7%	82.6%	73.1%	77.4%	85.3%	83.1%	74.6%	70.2%	75.9%	72.0%	85.0%	
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Nov-24	92.2%	90.2%	95.1%	96.5%	95.0%	99.0%	95.5%	95.6%	88.9%	94.2%	96.0%	96.0%	
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Nov-24	72.4%	77.6%	77.5%	75.9%	74.1%	79.2%	79.0%	77.0%	70.5%	75.4%	75.0%	77% by Year end	
Mental Health	Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Sep-24	3910		1845	1750	8365	1060	1855	945	3580	22995			
	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Sep-24	84.0%		64.0%	100.0%	77.0%	55.0%	69.0%	69.0%	71.0%	75.0%	60.0%	60.0%	
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	Q2 24/25	51.0%		49.0%	59.6%	54.0%	46.0%	53.0%	60.3%	51.3%	52.0%	-	60.0%	
	Dementia Diagnosis Rate	Nov-24	67.3%		67.3%	71.9%	66.7%	68.0%	62.9%	67.9%	67.1%	67.4%	66.7%	66.7%	
	CYP Eating Disorders Routine (NEW)	Sep-24	98.0%		100.0%	100.0%	64.0%	100.0%	95.0%	100.0%	59.0%	61.0%	84.0%	95.0%	
	CYP Eating Disorders Urgent (NEW)	Sep-24	82.0%		-	-	89.0%	-	-	-	-	100.0%	90.0%	95.0%	
	CYP 1+ Contacts (NEW) - % LTP trajectory achieved	Sep-24	73.6%		91.0%	118.1%	98.1%	147.0%	101.2%	63.5%	83.9%	92.0%	100.0%	95.0%	
	Perinatal Access (NEW) - % LTP trajectory achieved	Sep-24	141.3%		122.8%	128.8%	115.6%	138.2%	132.1%	114.1%	108.7%	135.4%	127.0%	100.0%	
	Talking Therapies completing a course of treatment (NEW) - % of LTP trajectory	Sep-24	102.0%		124.8%	81.7%	91.0%	115.4%	89.2%	61.7%	66.7%	78.1%	105.0%	100.0%	
	Talking Therapies Reliable Recovery (NEW)	Sep-24	49.0%		49.0%	45.0%	46.0%	48.0%	49.0%	47.0%	49.0%	53.0%	48.0%	48.0%	
	Talking Therapies Reliable Improvement (NEW)	Sep-24	70.0%		68.0%	67.0%	61.0%	67.0%	62.0%	71.0%	64.0%	76.0%	66.0%	67.0%	
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT.														

4. Place Aggregate Position

Category	Metric	Latest period	Sub ICB Place									ICB *	Local Trajectory	National Target	
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton				S/port & Formby
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Nov-24	10		10	5	20	5	10	20	10		80	-	-
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Oct 24 YTD	36.2%		43.0%	33.9%	39.4%	38.6%	41.4%	40.7%	33.0%		38.2%	32.9%	75% by Year end
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Oct-24	87.4%		86.6%	81.3%	84.8%	80.3%	94.0%	86.3%	85.2%	96.4%	85.0%	70.0%	70.0%
	Virtual Wards Utilisation Number only (NEW)	Nov-24	62	76	1	32	73	34	14	15	23		330		
	Community Services Waiting List (Adults) (NEW) - data only available at ICB/Provider level												54830		
	Community services Waiting List (CYP) (NEW) - data only available at ICB/Provider level												23542		
	Community Services – Adults waiting over 52 weeks (NEW) - data only available at ICB/Provider level												433		
Primary Care	Number of General Practice appointments delivered against baseline (corresponding month same period last year)	Nov-24	98.9%	96.4%	95.4%	102.4%	94.5%	93.3%	104.0%	96.4%	103.5%		97.6%	-	-
	Percentage of appointments made with General Practice seen within two weeks	Sep-24	88.6%		89.5%	87.2%	92.3%	90.7%	90.4%	84.3%	93.2%		90.0%	85.0%	85.0%
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Jun-24	6.77%		9.06%	6.18%	7.21%	5.61%	6.58%	6.12%	7.75%		7.12%	10.0%	10.0%
	Total volume of antibiotic prescribing in primary care	Jun-24	0.93		1.12	0.95	1.05	1.18	1.19	1.08	1.10		1.04	0.871	0.871
Integrated care - BCF metrics ***	Unplanned hospitalisation for chronic ambulatory care sensitive conditions ***	Q2 24/25	172.4	204.0	218.0	166.7	286.5	238.9	293.1	229.0	189.2		222.0	-	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Oct-24	89.5%	90.4%	93.7%	95.0%	95.5%	94.5%	95.2%	95.5%	92.1%		93.2%	-	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 ***	Q2 24/25	507.8	533.4	447.1	375.8	761.5	540.6	623.8	469.4	475.9		526.1	-	-
Note/s	<p>* 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</p> <p>** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT.</p> <p>*** Awaiting clarification from NHSE re: metric criteria. Plans are no longer comparable to actuals largely due to implementation of SDEC (Type 5) in year but also revisions to National criteria which systems need time to adopt and validate.</p>														

4. Place Aggregate Position

Category	Metric	Latest period	Sub ICB Place									ICB *	Local Trajectory	National Target	
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton				S/port & Formby
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q1 24/25	66.9%		64.4%	65.1%	67.5%	65.6%	60.8%	68.6%	64.1%		65.8%	77.0%	80.0%
	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with lipid lowering therapies (NEW)	Q1 24/25	61.1%		64.8%	60.5%	64.2%	61.5%	63.3%	62.6%	60.4%		62.2%		65%
	Smoking at Time of Delivery (NEW)	Q2 24/25	5.4%		7.4%	6.9%	5.9%	9.8%	8.5%	11.5%	5.3%		6.8%		<6%
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.	Dec-24	11.19%	12.04%	13.97%	9.39%	16.07%	13.21%	16.68%	17.16%	13.32%		13.5%	12%	12%
Continuing Healthcare	Referrals completed within 28 days	Q2 24/25	55.9%		81.8%	84.8%	47.9%	50.0%	94.3%	85.7%	49.2%	49.3%	64.70%	>80%	>80%
	% DST's (Decision Support Tool) completed that were in Hospital	Q2 24/25	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	<15%	
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q2 24/25	20.58		29.57	20.72	23.85	37.13	20.71	27.65	61.12	81.90	29.15	<18	
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q2 24/25	60.2		72.5	39.5	45.3	35.9	30.7	42.9	55.7	84.7	53.36	34	
Quality & Safety	Still birth per 1,000 - data only available at ICB/Provider level														
	Healthcare Acquired Infections: Clostridium Difficile - Place totals	12 months to Oct 24	(208 Vs 156)		(142 Vs 131)	(69 Vs 45)	(136 Vs 172)	(43 Vs 47)	(70 Vs 47)	(46 Vs 33)	(37 vs 100)		738	439	439
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Oct 24	220		109	83	164	66	89	37	75		829	518	518
Finance	Overall Financial position Variance (£m)	Nov-24	-8.0	-4.1	-10.0	-1.2	-9.5	-2.3	-0.9	-2.2	-8.3		5.8	0.0	0.0
	Efficiencies (Variance)	Nov-24	-0.7	-1.4	-1.9	0.2	-2.4	-0.8	0.0	0.0	-0.6		0.0	0.0	0.0
	Mental Health Investment Standard met/not met (MHIS)	Nov-24	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Yes	Yes
	BCF achievement (Places achieving expenditure target)	Nov-24	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	9/9	9/9
Note/s	<p>* 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</p> <p>** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT.</p> <p>*** Local trajectories set by Place as part of their BCF submissions to NHSE, therefore RAG rating will vary for Places with lower/higher trajectories</p> <p>**** 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</p>														

5. Exception Report – Urgent Care

Ambulance category 2 mean response time

Latest ICB Performance (Dec-24)

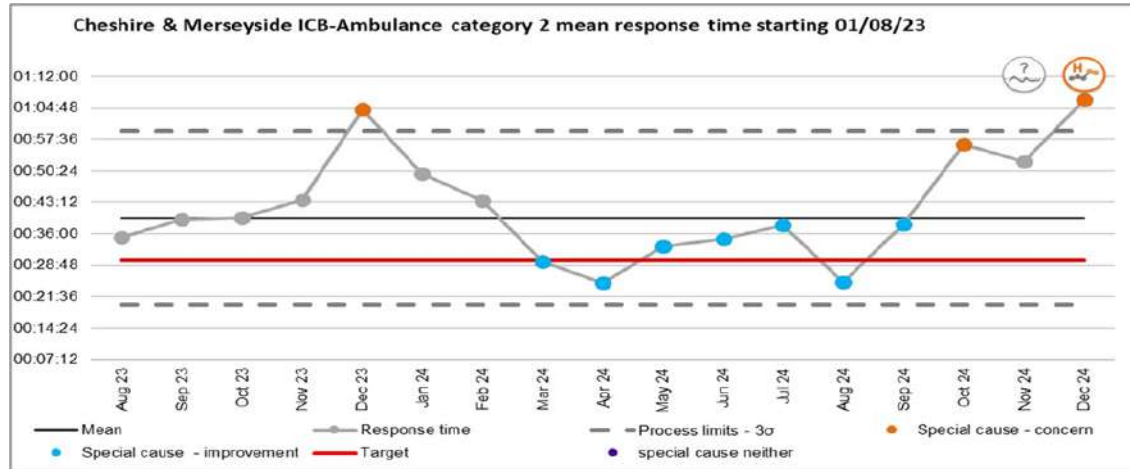
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National Ranking

n/a

ICB Trend (Dec-24)

Deteriorated



Issue

- C&M not meeting CAT 2 response time.

Action

- Each locality across C&M is working with ECIST and the ICB admission avoidance at scale group to implement call before convey as a key mitigation, along with existing in-hospital actions.
- Most advanced is Wirral's right care offer which is a 7-day service 8-8 accessing both hospital and community services, with the majority of patients diverted to community teams.
- COCH and Liverpool went live with call before convey on 20 January.
- MWL due to expand its offer from 10 Feb including input from community provider bringing together their SPOA and MDT hub, with WHH also adopting a similar approach.
- NWAS supporting with communications out to crews and engagement sessions.
- AQUA is supporting the ambulance improvement group to review ambulance handover processes and to support consistency of approach across C&M acute sites.

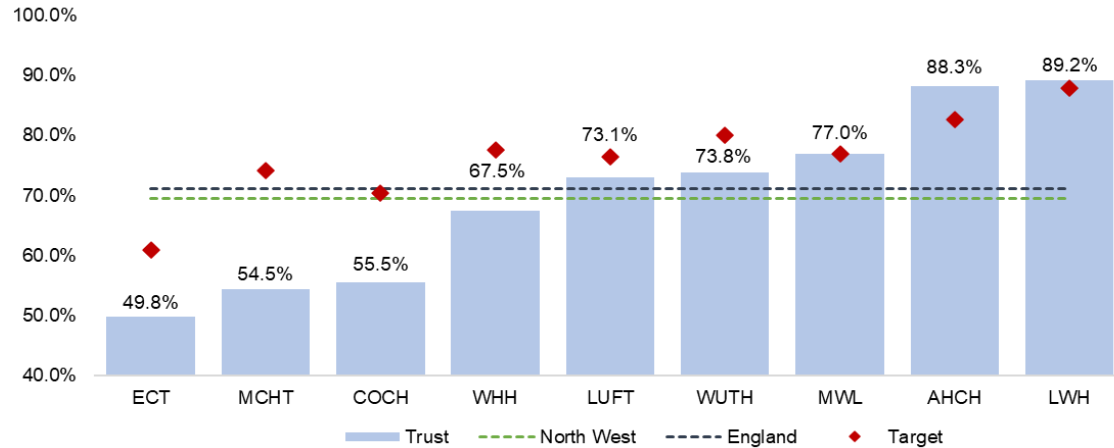
Delivery

- Within the UEC Recovery programme providers and improvement support are collectively working to improve Cat 2 response times, however the performance context remains extremely challenging.

5. Exception Report – Urgent Care

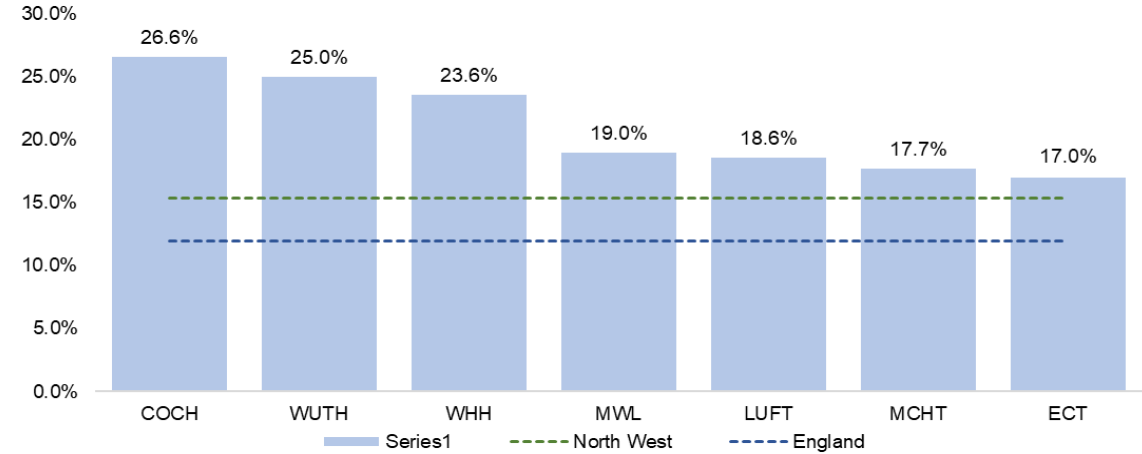
A&E 4 hour waits from arrival

Latest ICB Performance (Dec-24)	71.4%	National Ranking	20/42
Provider Breakdown (Dec-24)			Deteriorated



A&E 12 hour waits from arrival

Latest ICB Performance (Dec-24)	18.3%	National Ranking	38/42
Provider Breakdown (Dec-24)			Deteriorated



Issue

- Cheshire and Merseyside performance is 5.8% below the in-year trajectory that has been set to achieve the 78% March 2025 ambition whilst 18.3% of patients were delayed over 12 hours compared to the North West average of 15.4% and the England average of 12.0%.
- Although this report focuses on December performance, it should be noted that considerable pressures have been experienced in January. Three acute Trusts (MWL, LUFT and WUTH) declared critical incidents in the first week of January. Thanks to significant partnership efforts and a coordinated response, all three Trusts have successfully stood down from their critical incident status.

Action

- ECIST is working with C&M Emergency Departments through the Tier 1 Rapid Improvement Offer with a focus on reducing the number of patients waiting over 12 hours in department. This offer has been extended until the end of March, and engagement is ongoing with Trusts to develop further offers of support.
- Each C&M locality continues to work closely to sustain system wide communication, escalation and actions and to ensure patient safety is our focus, despite pressures being experienced.
- A clinical consensus group has been set-up and is working through the national shared risk assessment framework to support shared risk management across the system.
- A reduction in 12-hour time in department is dependent upon overall flow from ED to specialty wards. There is a focus on reducing in-hospital Length of Stay (LOS) and No Criteria to Reside (NCTR) within the Tier 1 ECIST work and the LOS and acute discharge UEC recovery workstreams. WUTH, LUFT and WHH continue to operate a continuous flow model to increase flow from ED on to AMU/wards.
- East Cheshire have demonstrated a significant improvement in a reduction in time lost over 12hrs. In early November, the baseline was 186hrs reduced to 52hrs on 10th December.

Delivery

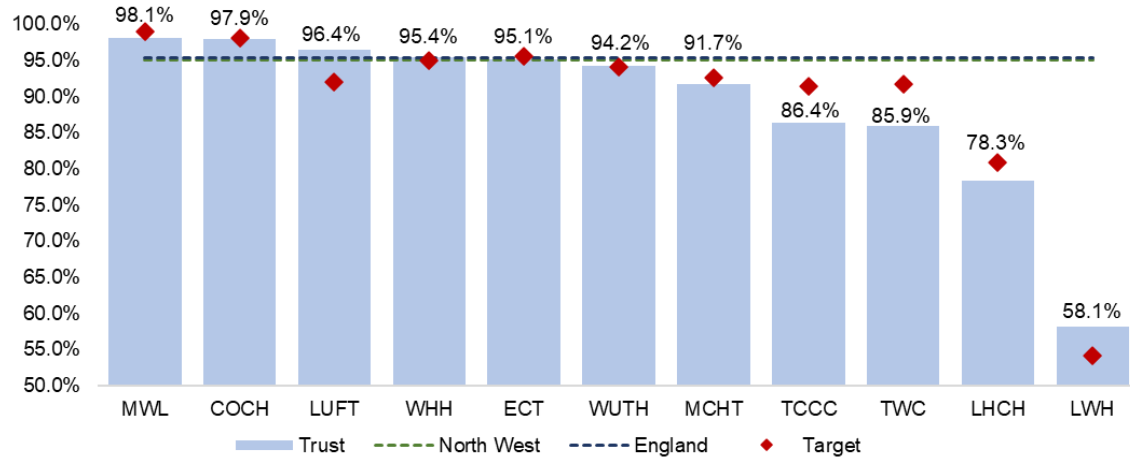
- C&M is adopting a recovery approach to UEC in 2024/25 and is committed to achieving 78% by the end of 2024/25 and a reduction in 12 hour waits

5. Exception Report – Urgent Care

Adult G&A bed occupancy

Latest ICB Performance (Dec-24) **96.0%** National Ranking **29/42**

ICB Trend (Dec-24) **Improved**



Issue

- General and acute (G&A) bed occupancy is consistently high across acute trusts in C&M, with no special cause variation. Long length of stay numbers are a key driver of high occupancy.

Action

- A combination of MADE events and other targeted winter plan measures resulted in C&M reducing acute bed occupancy to 92% in the immediate run up to the Christmas period.
- This provided a degree of resilience going into the new year, without which the pressures that have been reported above would have been considerably more challenging.
- As would be expected, occupancy levels have reverted to the high levels we would expect for January. C&M Trusts continue to receive the Tier 1 rapid improvement offer (RIO), focussed on improving both the number of discharges and also the profile of discharges through the day, supported through the UEC Recovery Programme.

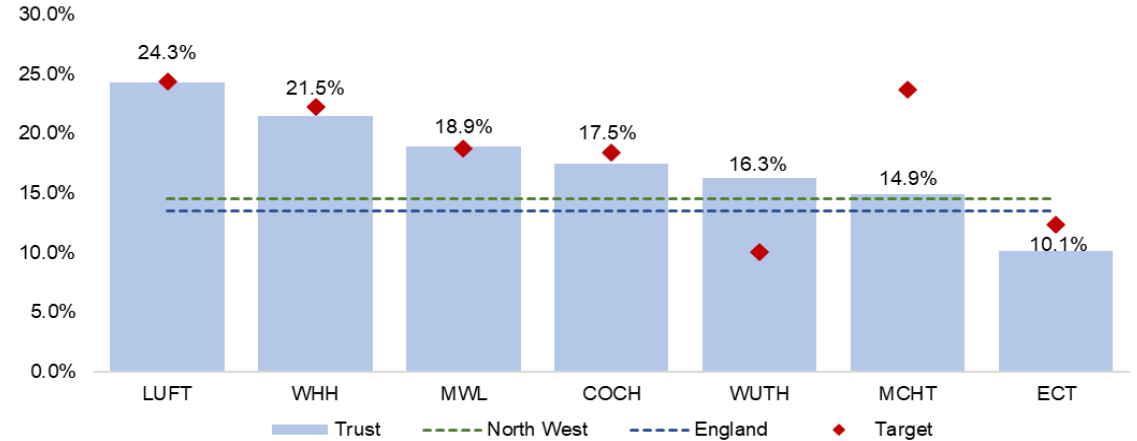
Delivery

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

No Criteria To Reside (NCTR)

Latest ICB Performance (Dec-24) **19.5%** National Ranking **39/42**

ICB Trend (Dec-24) **Improved**



Issue

- NCTR is at 19.5%, substantially higher than England (13.5%) and North West (14.5%), with no special cause variation.

Action

- The C&M UEC Recovery Programme for 2024/25 has been aligned to 5 acute catchment areas: Wirral, Liverpool, Mersey & West Lancs, Warrington & Halton and Cheshire.
- Within this programme of work, the acute length of stay workstream supports improvement approaches aimed at reducing LoS, particularly for patients who no longer meet the criteria to reside in hospital.
- This includes a refresh of weekly Long Length of Stay reviews at every trust.
- Localities remain focussed on the development of care transfer hubs.

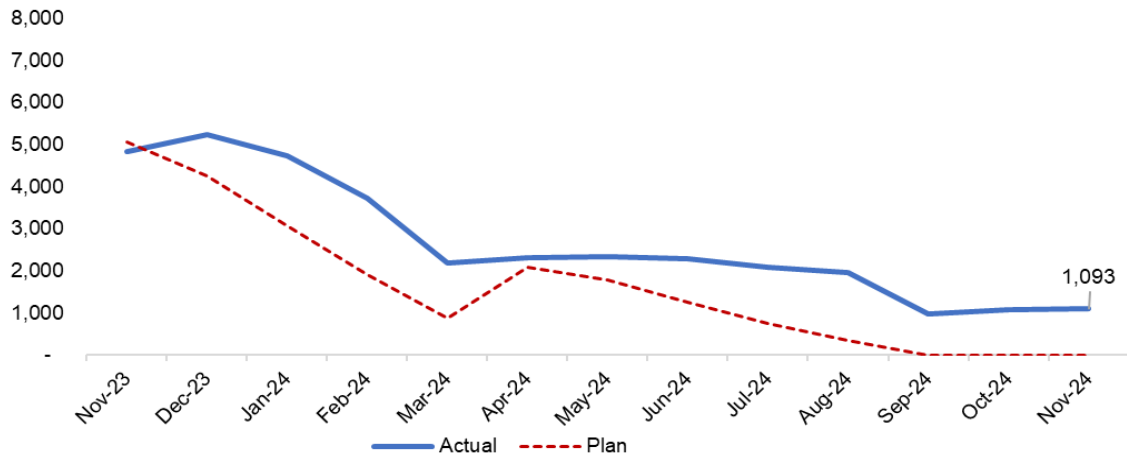
Delivery

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

5. Exception Report – Planned Care

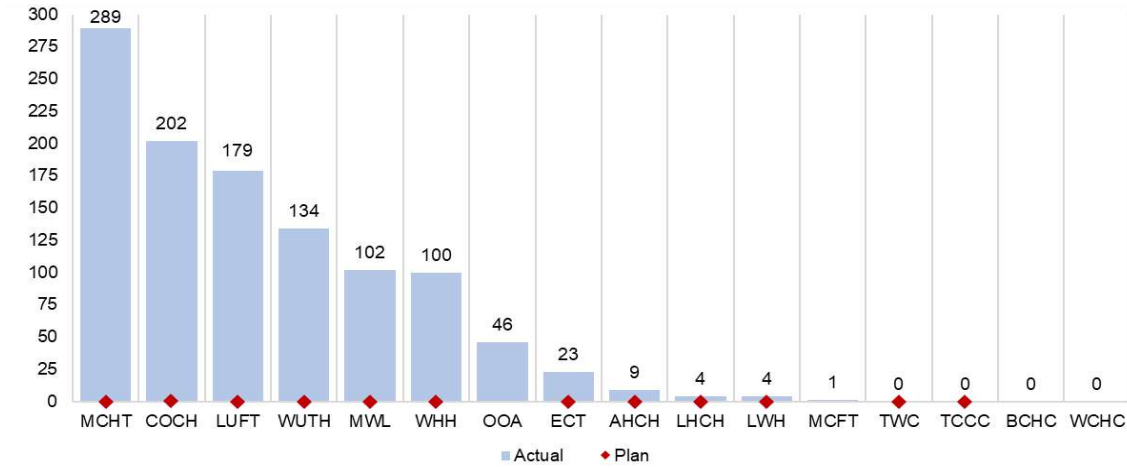
ICB incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Nov-24)	1,093	National Ranking	n/a
ICB Trend (Nov-24)		Deteriorated	



Trust incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Nov-24)	1,093	National Ranking	n/a
Provider Breakdown (Nov-24)		Deteriorated	



Issue

- Challenges remain for some trusts to clear 65 week wait patients, given patient choice and complexity issues. 3 providers are reporting anticipated capacity breaches at month end which has reduced from 7.
- A residual position of 851 65-week capacity breaches are anticipated to be reported for January month end. Within this, the most challenged provider is MCHT with 330 potential capacity breaches. However, there are a number of recovery actions in place to reduce this number. In addition, LUFT have some risks around ENT which will be mitigated by the use of outsourcing which has been confirmed for 800 pathways.

Action

- C&M have organisations who are anticipating residual risks around sustaining 65-week delivery in January and February and the team are working closely with providers to ensure that all mutual aid and operational tactical measures undertaken to support the position. C&M currently have 11 active mutual aid requests within, Hysteroscopy & Biopsy, Oral & Max Fax, Plastics, General Surgery, Vascular, T&O, Gynae, and pain.
- Validation SDF funding agreed per Trust, detailed narrative/plans received and trajectories of performance improvement in development. This has shown an improvement and is currently being reviewed.
- At MCHT, the trust continues to experience significant pressures within Cardiology, Rheumatology and T&O. The trust has also submitted mitigation plans for other challenged specialties and is subject to additional oversight from NHS England, with daily support in place from CMAST.
- At LUHFT, ENT and Oral and Maxillofacial Surgery are the most challenged specialties. A business case has now been approved by executive board for the use of outsourcing for ENT pathways to improve the position for January and February. Mobilisation underway.
- At COCH, ENT insourcing has been approved to support the delivery of 65ww's, this continues and is making impact – allowing Countess to not report any breaches.
- Provider action plans have been received for the continued reduction of long waits. These are reviewed during regular trust Patient Tracking List (PTL) meetings.
- 65-week returns will continue to be submitted weekly to review patient numbers and plans, where complex patients are being identified and discussed during PTL meetings so that additional support can be provided. Daily reporting in place for the most challenged organisations.

Delivery

- There is a continued focus on eradicating 65 week waits and to model the delivery of 52 and 18 weeks for future planning.
- Working towards the ICB ambition of zero CYP patients waiting over 52 weeks by the 31st March 2025. This remains on plan with some risks across East Cheshire and Alder Hey.

5. Exception Report – Cancer Care

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

Latest ICB Performance (Nov-24)

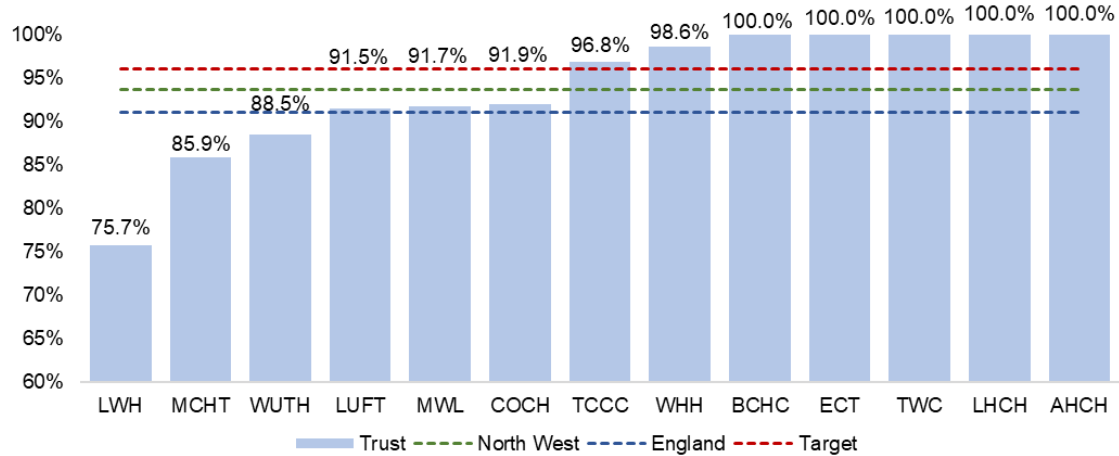
94.2%

National Ranking

10/42

Provider Breakdown (Nov-24)

Deteriorated



Issue

- C&M is not yet achieving the 96% 31-day combined standard required however, the figure of 94.2% is 6th amongst Cancer Alliances and 10th amongst ICBs in this latest month.

Action

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

Delivery

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

5. Exception Report – Mental Health

People with SMI receiving a full annual physical health check

Latest ICB Performance (Q2-24/25)

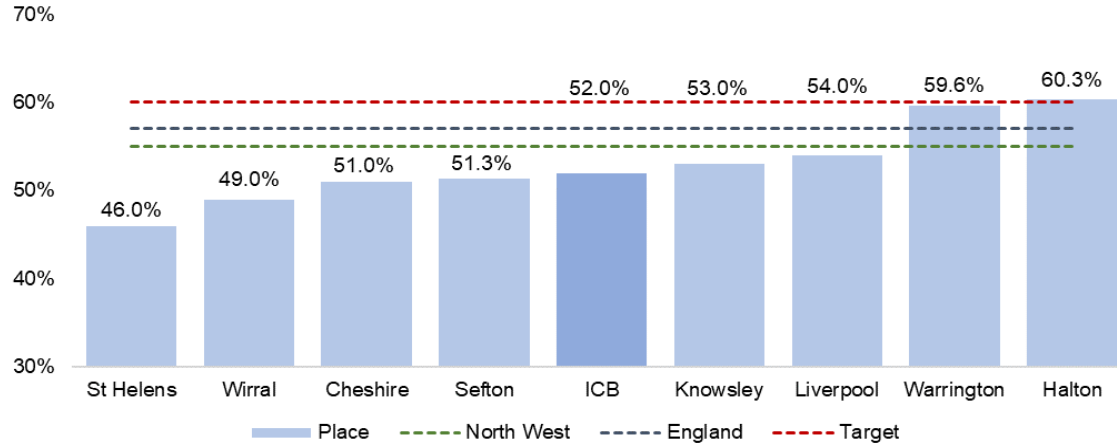
52.0%

National Ranking

34/42

Place Breakdown (Q2 – 24/25)

Deteriorated



Issue

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

Action

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

Delivery

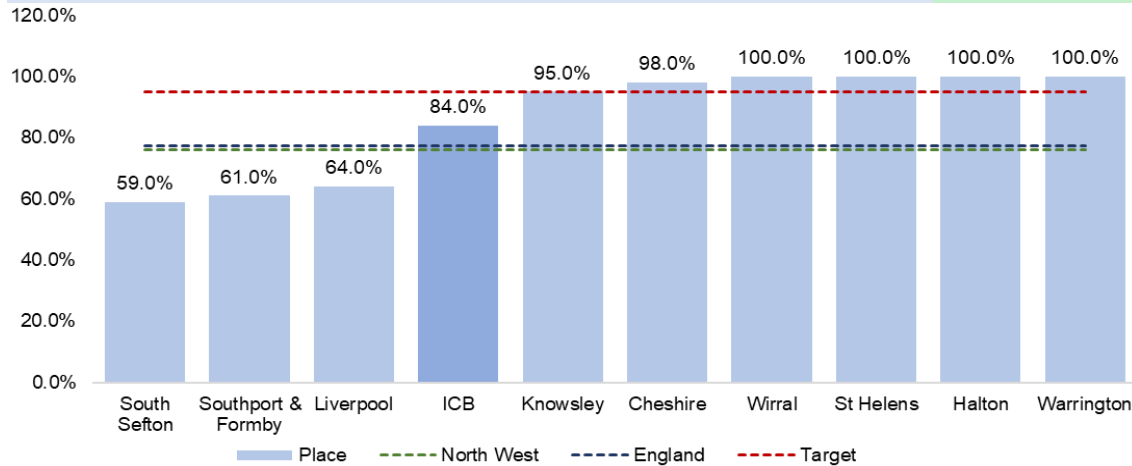
- Support is being offered to practices which are not meeting targets.
- All places have a local SMI steering group where performance is managed and local improvement initiatives are developed.
- Historic annual data indicate a downward trend through the year with a surge in Q4 which minimises the opportunity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

5. Exception Report – Mental Health

CYP Eating Disorders Routine

Latest ICB Performance (Oct-24) **84.0%** National Ranking **18/40**

Place Breakdown (Oct-24) **Improved**



Issue

- The reported data shows C&M not achieving the routine waiting time standard for CYP with Eating Disorders (target 95% seen within 4 weeks), however this is not an accurate reflection of service waiting times. This is due to data quality issues in the MHSDS, predominantly at Alder Hey.

Action

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

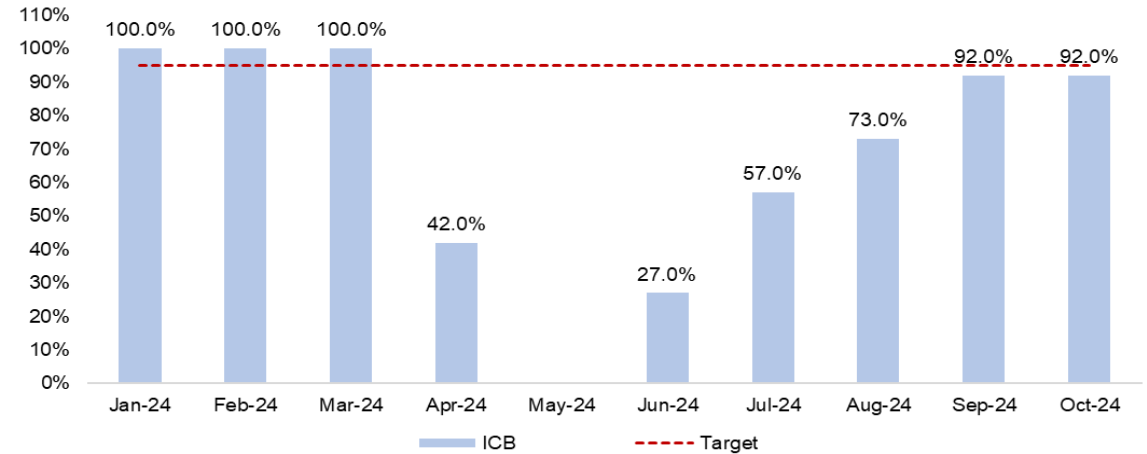
Delivery

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

CYP Eating Disorders Urgent

Latest ICB Performance (Oct-24) **90.0%** National Ranking **12/25**

Place Breakdown (Oct-24) **Improved**



Issue

- The reported data shows C&M not achieving the urgent waiting time standard for CYP with Eating Disorders (target 95% seen within 1 week), however this is not an accurate reflection of service waiting times. This is due to data quality issues in the MHSDS.

Action

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

Delivery

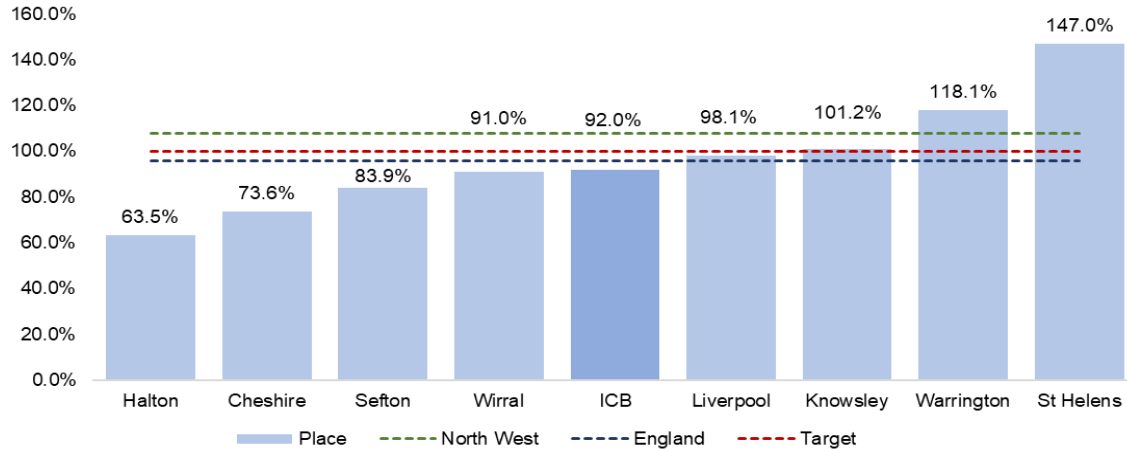
- Providers continue to monitor service waits locally - local data shared at weekly divisional meetings indicates 98% - 100% of urgent are being seen, above the 95% target.

5. Exception Report – Mental Health

CYP 1+ Contacts: % LTP trajectory achieved

Latest ICB Performance (Oct-24) **92.0%** National Ranking **21/42**

Place Breakdown (Oct-24) **No change**



Issue

- The CYP access target is 37,590 for C&M. October data indicates that the target is not currently being met, with 34,730 CYP accessing support in C&M over the last rolling 12 months.
- Not all VCSE services are able to flow data to the national dataset so this activity is not captured in its totality.

Action

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

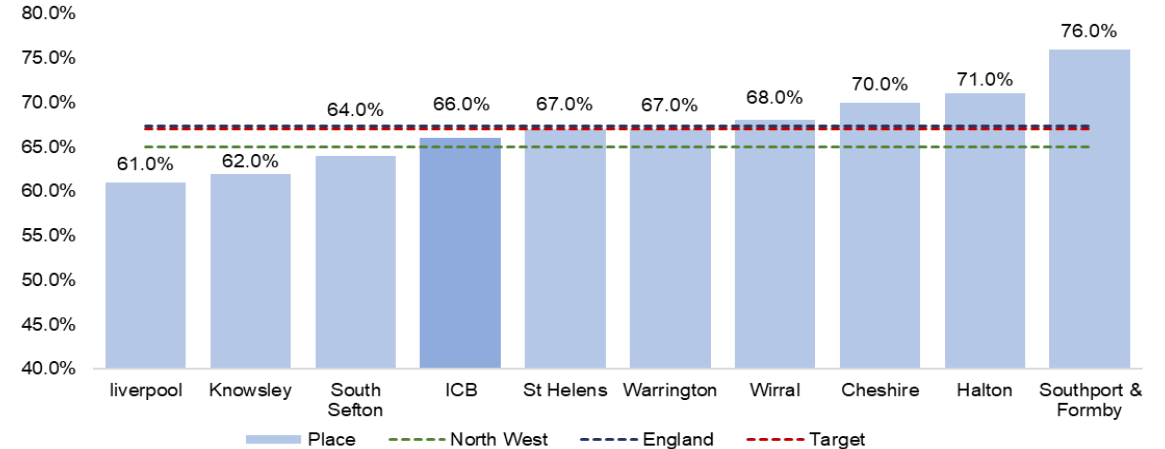
Delivery

- There has been no significant change in overall C&M access rates during 2024, however there is more significant variance in place level trends with Southport and Formby, Warrington and St. Helens evidencing a month on month increase in access.

Talking Therapies Reliable Improvement

Latest ICB Performance (Oct-24) **66.0%** National Ranking **31/42**

Place Breakdown (Oct-24) **Improved**



Issue

- C&M ICB is 1% below the national metric for reliable improvement but have achieved the reliable recovery target in Oct 2024.

Action

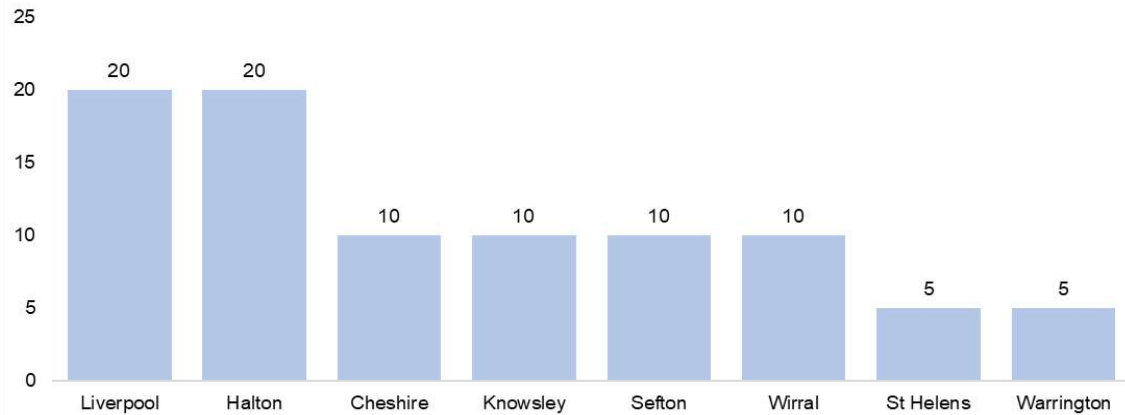
- The C&M Talking Therapies Steering Group and Workforce Group continue to focus on actions required to achieve national metrics. These actions include a review of data with service providers. A further request has been made to the national team by Mersey Care to explore a data refresh for June 2024 to rectify a data quality issue to ensure annual performance levels are correctly reported.

Delivery

- Reliable improvement rates in Liverpool and Knowsley have been between 1% and 10% below target throughout the year. All other places are achieving target.
- Performance is expected to improve in future months.

5. Exception Report – Learning Disabilities

Adult inpatients with a learning disability and/or autism			
Latest ICB Performance (Nov-24)	80 *	National Ranking	25/42
Place Breakdown (Nov-24)			Improved



Issue

- There are currently 82 adult inpatients as at 20 December 2024, of which 49 are Specialised Commissioning (Spec Comm) inpatients commissioned by NHSE, and 33 ICB commissioned. The target identified for C&M (ICB and Spec Comm) is 60 or fewer by the end of Q4 2025

Action

- The Transforming Care Partnership (TCP) has scrutinised those clinically ready for discharge. Of those 82 adults, 10 individuals are currently on Section 17 Leave. There have been discharges during Q3, but it is expected that some of the existing section 17 individuals will be discharged in Q4 pending MOJ Clearance.
- Data quality checks continue to be completed on Assuring Transformation to ensure accuracy.
- Weekly C&M system calls ongoing to address Delayed Discharges with Mersey Care and CWP.
- Housing Lead continues to work to find voids which can accommodate delayed discharges.
- Desk top reviews take place to address section 17 leave progress.

Delivery

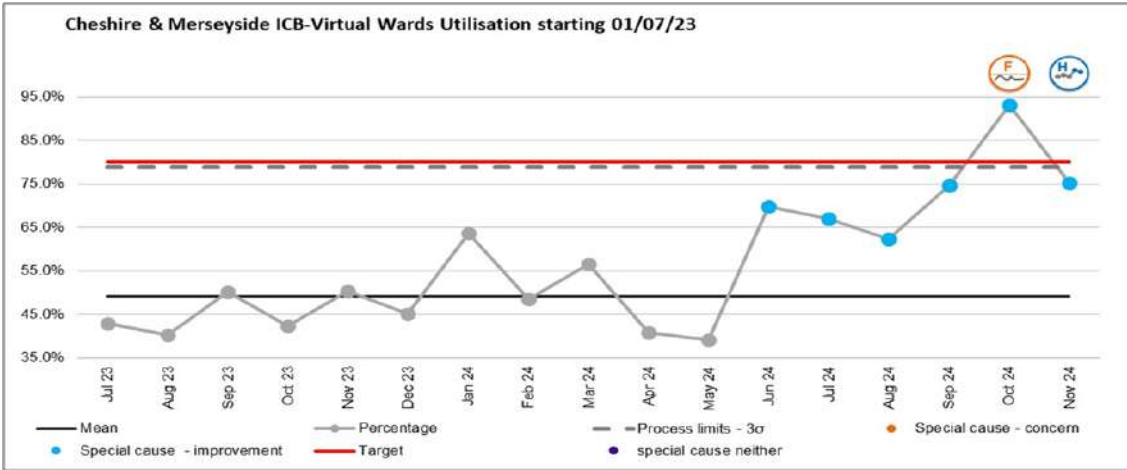
- C&M ICB and NHSE aim to reduce the number of inpatients, where appropriate, by the end of Q4 2024/25, where the target is 60. Over the latest 12-month period, the adult inpatient cohort has reduced by 261 (76%) from 342 to 82 but Autism admissions continue to increase.

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

5. Exception Report – Community

Virtual Wards Utilisation

Latest ICB Performance (Nov-24)	75.2%	National Ranking	5/42
ICB Trend (Nov-24)		Deteriorated	



Issue

- Variation in utilisation continues due in part to a reliance on single handed clinicians with responsibility for oversight of virtual ward patients. This issue is more apparent during periods of higher-than-normal seasonal annual leave.
- Data reporting arrangements during this period were based on a weekly snapshot of utilisation rather than live data flow and therefore subject to fluctuation.

Action

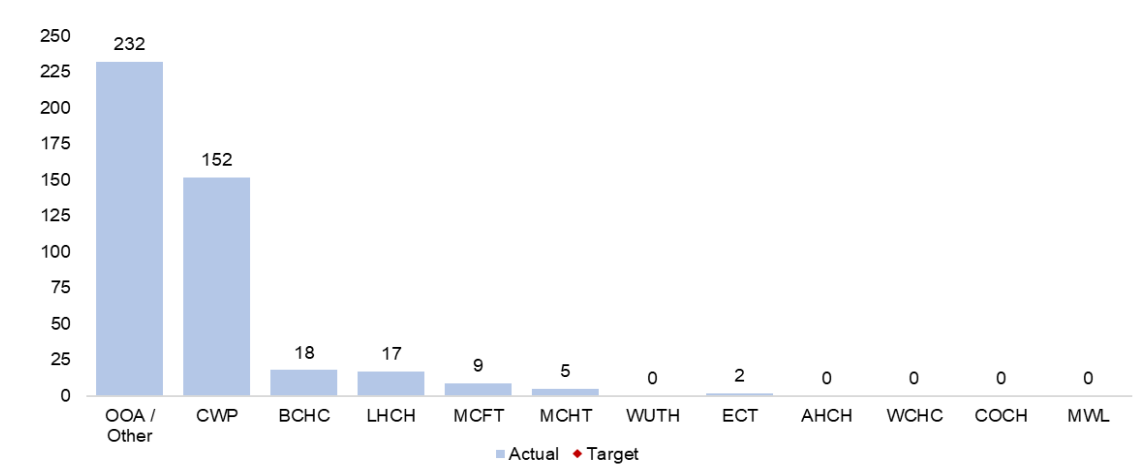
- Cover arrangements for annual leave are being reviewed through the virtual ward clinical reference group.
- Data reporting transitioned from a weekly snapshot to a live feed in December 2024.

Delivery

- The continuation of an improving trajectory from May 2024 is expected to continue into Q3 and Q4 of 2024/25.

Community Services – Adults waiting over 52 weeks

Latest ICB Performance (Oct-24)	435	National Ranking	n/a
Provider Breakdown (Oct-24)		Deteriorated	



Issue

- OOA/other waits relate predominantly to a single provider, HCRG Care Group.
- HCRG Care Group has its head office in C&M but delivers services nationally. The over 52 week waits relate to non-C&M patients for services provided by HCRG Care Group elsewhere in the UK.
- The ICB has an ENT and Dermatology contract with HCRG for services provided in the Wirral area, but it is not thought that these waits refer to this contract.
- The provider collaborative data quality group have reviewed the remaining long waits and identified that 148 of the 152 long waits within CWP are incorrectly recorded.

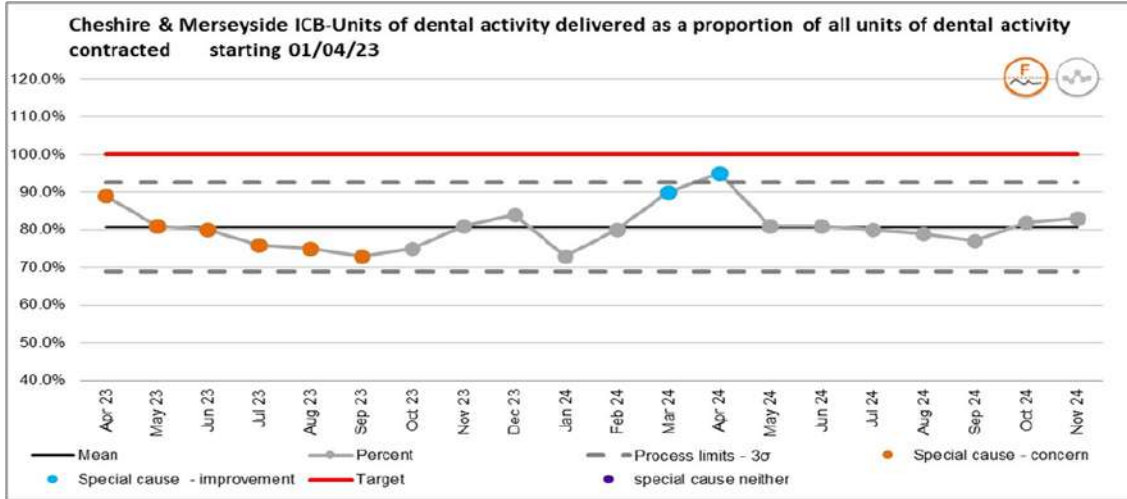
Action

- There is a piece of work ongoing with the provider collaborative and the BI team looking at HCRG data quality and validation in conjunction with NHS England.
- The CWP data anomaly will be rectified within the next reporting period.

5. Exception Report – Primary Care

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

Latest ICB Performance (Nov-24)	83.0%	National Ranking	26/42
ICB Trend (Nov-24)		Improved	



Issue

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

Action

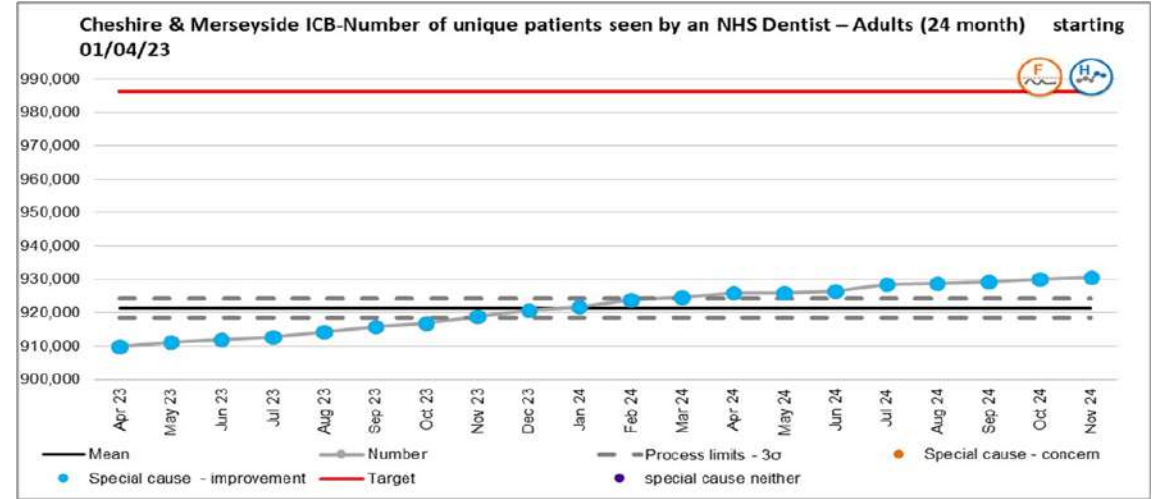
- Providers underperforming were issued with action plans as part of the Mid-Year review process.
- Commissioners will review provider responses to Action Plans and support where delivery can be improved.
- Consideration will be given to reallocation of UDA's subject to ICB approval

Delivery

- Fluctuations in delivery of target are expected throughout the year such is the nature of national contract.
- Mid-Year Review process shows slight improvement when compared to 23/24.

Number of unique patients seen by an NHS Dentist – Adults

Latest ICB Performance (Nov24)	930,608	National Ranking	n/a
ICB Trend (Nov-24)			



Issue

- C&M does not currently meet the target.

Action

- Continue to support providers to see new patients who require an NHS dentist
- Implementation of local dental improvement plan Pathway 3 Access
- Implementation of national dental recovery plan – New Patient Premium.

Delivery

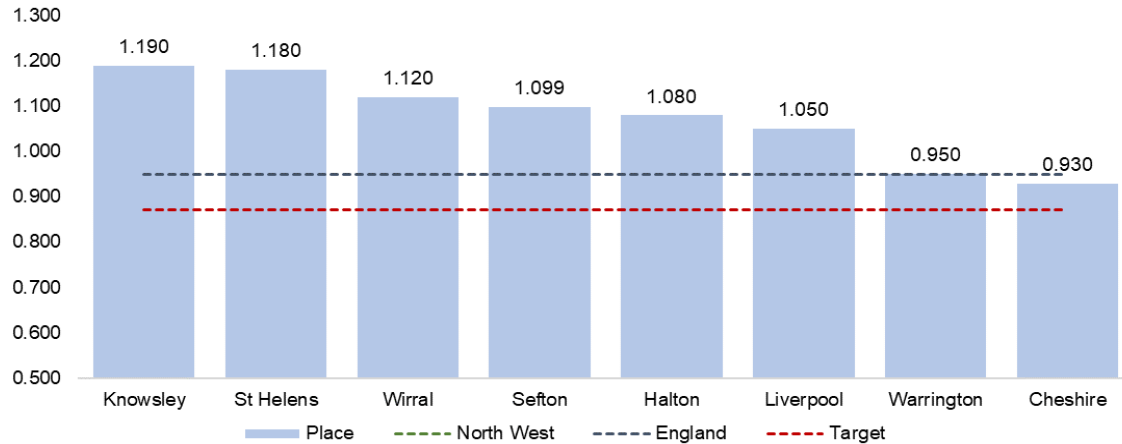
- Commissioners are using flexible commissioning arrangements to improve activity.
- Roll out of national Golden Handshake scheme to 7 C+M practices
- Review current data versus delivery to ensure alignment with vulnerable groups and health inequalities.

5. Exception Report – Primary Care

Total volume of antibiotic prescribing in primary care

Latest ICB Performance (Jun-24)	1.04	National Ranking	n/a
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Place Breakdown (Jun-24)	Deteriorated
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Issue

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

Action

- All Places working with primary care on cascading of education, public communication work, reviewing prescribing data and decisions in relation to antibiotic prescribing.
- C&M antibiotic prescribing data dashboard is being utilised to support targeted work.
- The C&M hydration team continue plans to roll out the project across C&M to reduce admissions related to Urinary Tract Infections.
- Task and finish group arranged to agree an electronic UTI assessment tool for use in care homes to streamline requests and promote best practice.
- The antimicrobial prescribing and medicines optimisation (APMO) workstream in NHS England has been collaborating over the last few months with GPs and medicines optimisation colleagues in ICBs to develop a suite of resources. Draft antibiotic prescribing improvement schemes are being reviewed across C&M to agree on a single audit that all places will look to complete during 2025/26.

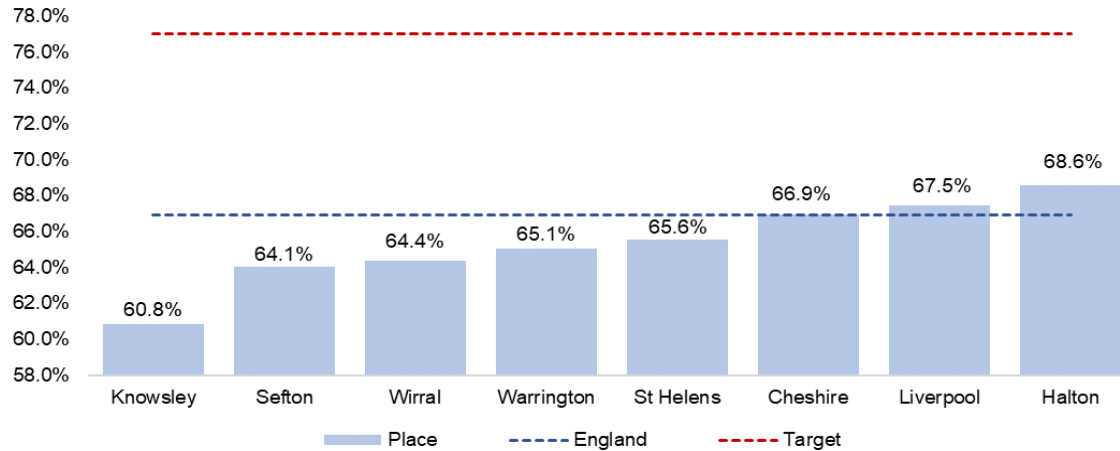
Delivery

- Analysis will continue with Q3 2024/25 data at Place and ICB level to identify areas to focus on additional to the planned work happening across C&M.

5. Exception Report – Health Inequalities & Improvement

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

Latest ICB Performance (Q1-24/25)	65.8%	National Ranking	29/42
Place Breakdown (Q1-24/25)			Deteriorated



Issue

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

Action

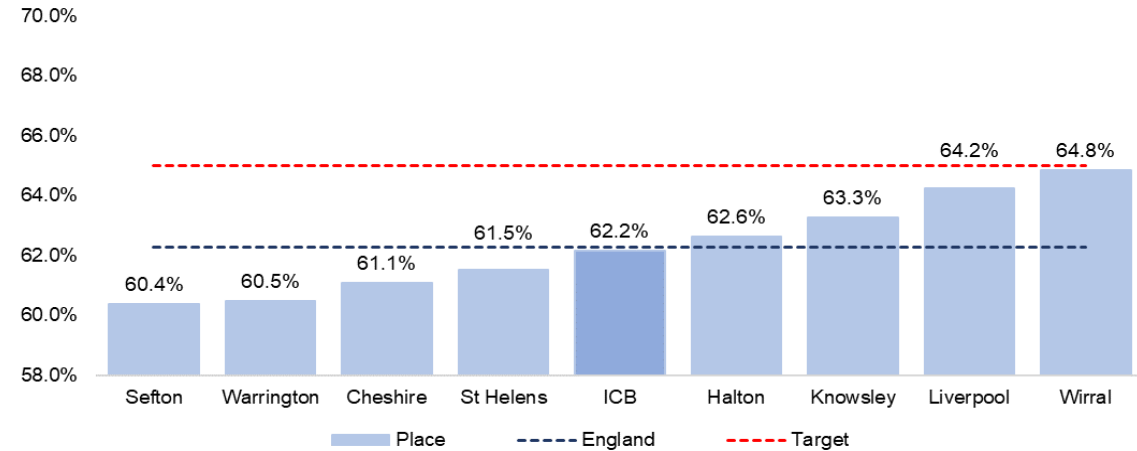
- Forums being established to collaborate on Health Checks and Hypertension.
- Local Quality Incentive Schemes, the role of community pharmacy and secondary care interface opportunities are being explored with the aim of ensuring these are considered as part of 25/ 26 Commissioning Intentions.
- Governance in place to oversee hypertension case finding pilots in optometry with leadership being provided by the Population Health team.
- Work planned with the most deprived practices re: hypertension is progressing; national funding from NHSE now confirmed.

Delivery

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

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

Latest ICB Performance (Q1-24/25)	62.2%	National Ranking	19/42
Place Breakdown (Q1-24/25)			NEW



Issue

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

Action

- Forums are being established to collaborate on Health Checks and Lipid management.
- Local Quality Incentive Schemes, the role of community pharmacy and secondary care interface opportunities are being explored with the aim of ensuring these are considered as part of 25/ 26 Commissioning Intentions.
- Recurrent funding secured for both the Familial Hypercholesteremia & CVD Prevention services. This provides opportunity to embed FH service into wider Lipid Management services.
- Active discussions on the C&M Lipid Management Pathway, its delivery and how to ensure cholesterol management is optimised.

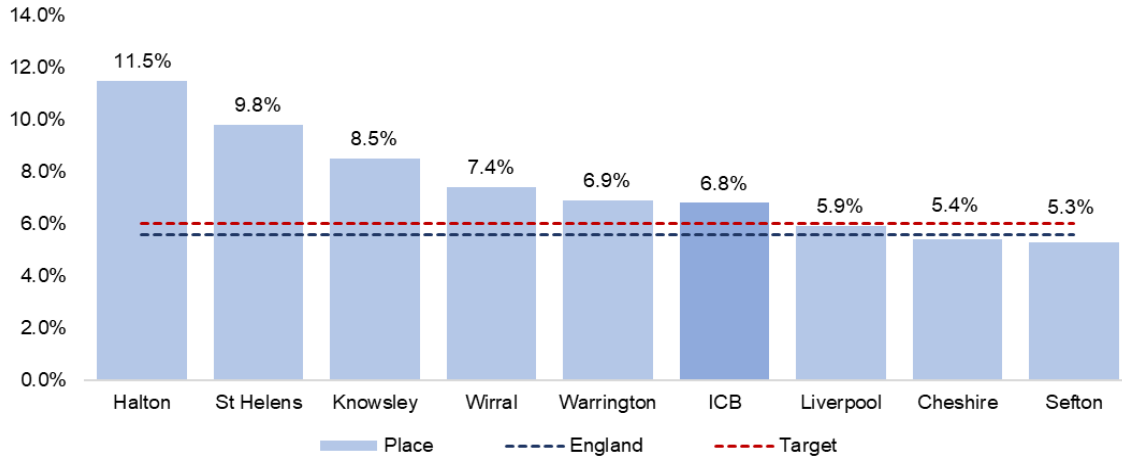
Delivery

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

5. Exception Report – Health Inequalities & Improvement

Smoking at Time of Delivery

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



Issue

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

Action

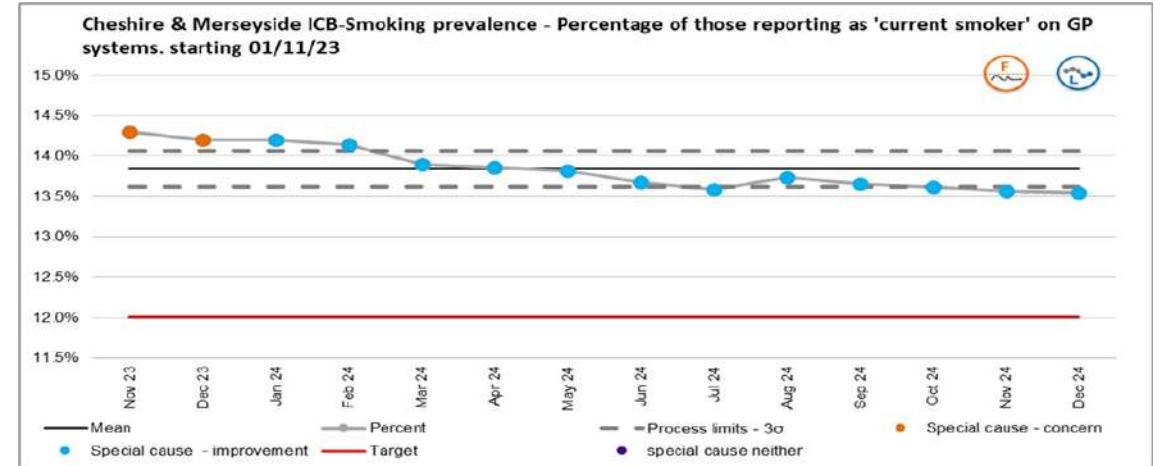
- NHS Digital Q2 statistics on Smoking at Time of Delivery published on 20/12/24 shows that C&M ICB figure dropped from 7.4% in Q1 to 6.8% in Q2 (England dropped from 6.5% to 6%). Our ICB and maternity treating tobacco dependency services are continuing to close the gap with England

Delivery

- Liverpool have successfully implemented the baby Clear Risk Perception intervention in the maternity pathway which ensures that most pregnant smokers engage with service offers and has seen their year-to-date SATOD fall to 6.3%. This is one of the lowest rates of 'smoking status not known at delivery' in the country, indicating the effectiveness of the pathway.
- Our dedicated WHaM leads for tobacco control have demonstrated excellent system working by supporting the onboarding to the new National Smokefree Pregnancy Incentive Scheme. All C&M Trusts are going through this process now.

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

Latest ICB Performance (Dec-24)	13.5%	National Ranking	n/a
Place Breakdown (Dec-24)			Improved



Issue

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

Action

- An NHSE business case has been approved securing funding for specialist face-to-face training to be delivered to newly recruited tobacco dependency treatment advisors across the NHS Trusts in C&M.
- An NHSE business case has been approved securing funding to support NHS Trusts to implement their smokefree policies ensuring that all NHS sites are health promoting environments.
- Our C&M All Together Smokefree multimedia campaign programme is due to launch on 31st December, complementing the national campaign to encourage quitting smoking as part of any new year resolutions.

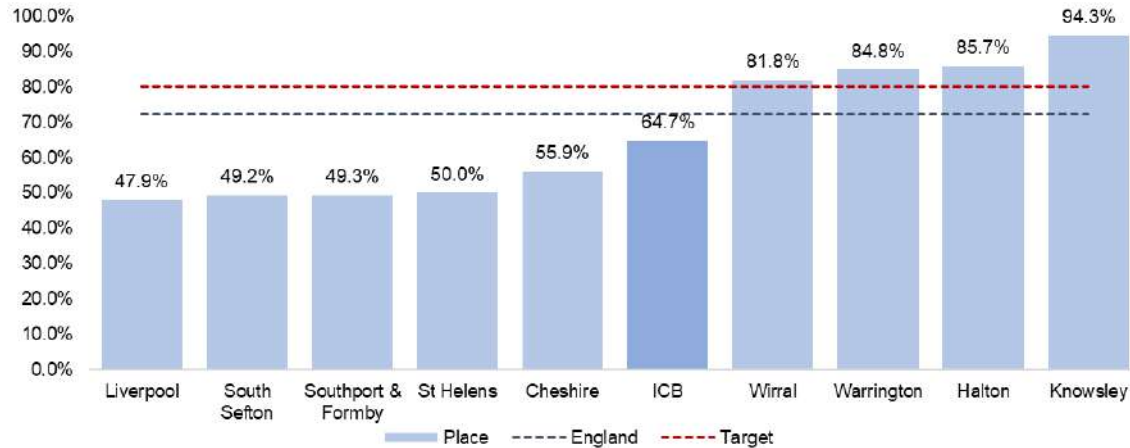
Delivery

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

5. Exception Report – Continuing Healthcare

Standard Referrals completed within 28 days

Latest ICB Performance (Q2-24/25)	64.7%	National Ranking	31/42
Place Breakdown (Q2-24/25)			Deteriorated



Issue

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

Action

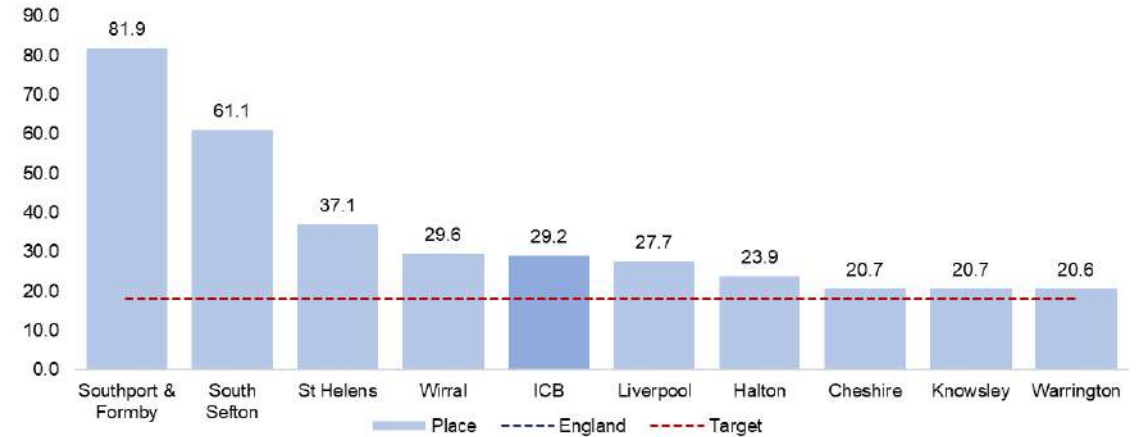
- A review of AACC delivery across C&M has taken place to develop a single structure and improve consistency and capacity across the 9 sub-locations. This includes the in-housing of Liverpool and Sefton place-based teams, which are the main outliers for this metric.
- Additional scrutiny of the in-housed service, alongside the appointment of an Interim Head of Service (pending permanent recruitment via the Management of Change process) has enabled allocated senior clinical resource to daily management of 28 day / long waits.

Delivery

- The ICB is already delivering at above the Quarterly trajectory agreed with NHS England. The Q1 projection was $\geq 65\%$ to 69.9%.

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

Latest ICB Performance (Q2-24/25)	29.15	National Ranking	36/42
Place Breakdown (Q2-24/25)			Improved



Issue

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

Action

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

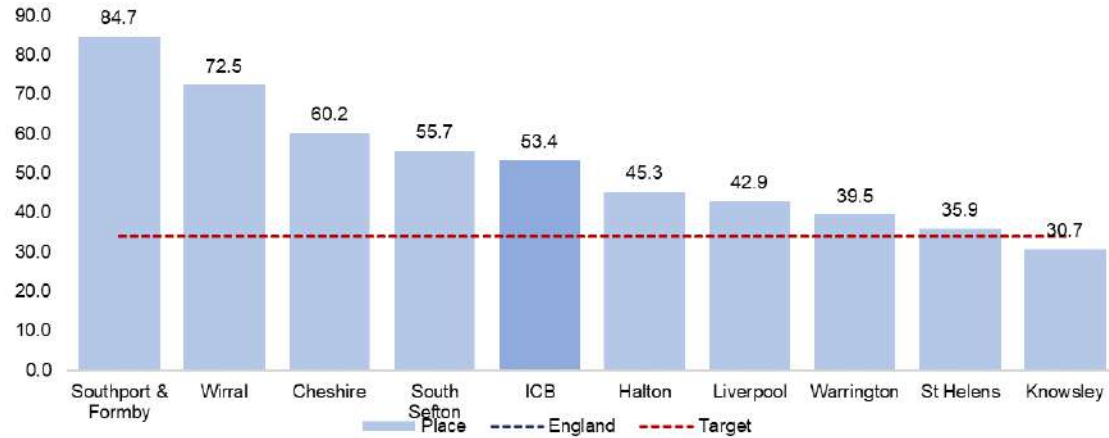
Delivery

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

*snapshot at end of quarter

5. Exception Report – Continuing Healthcare

Number eligible for standard CHC per 50,000 population *			
Latest ICB Performance (Q2-24/25)	53.36	National Ranking	39/42
Place Breakdown (Q2-24/25)			Improved



Issue

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

Action

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

Delivery

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

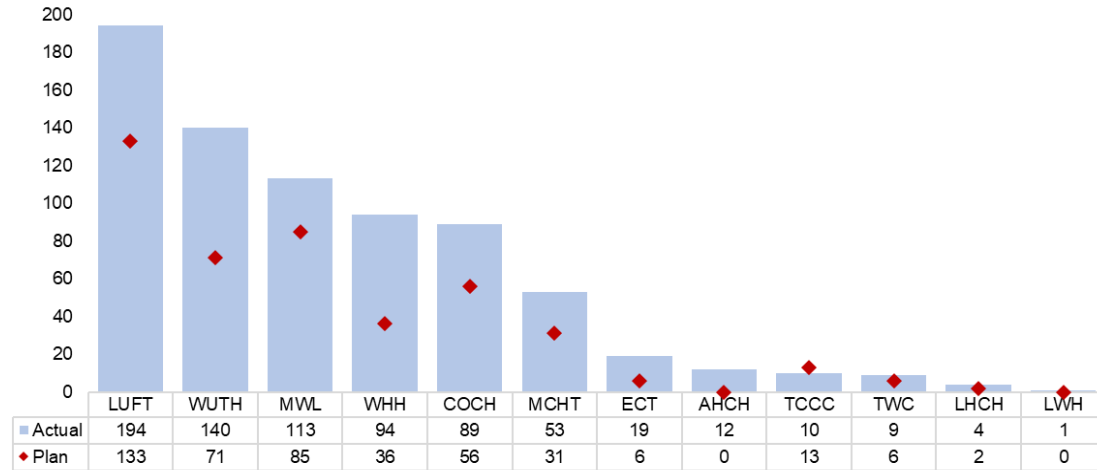
**snapshot at end of quarter*

5. Exception Report – Quality

Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation

Latest ICB Performance (12 months to Oct-24) **738** National Ranking **23/42**

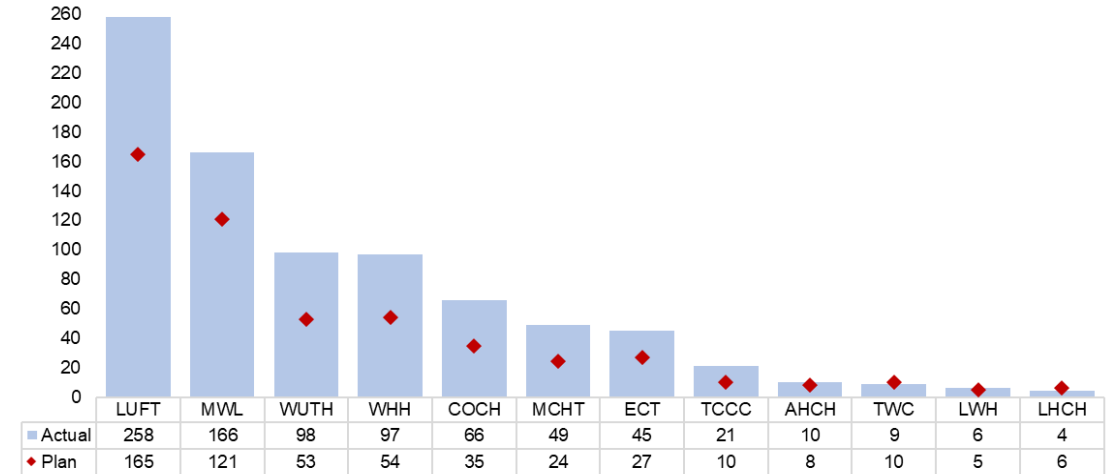
Provider Breakdown (rolling 12 months to Oct-24)



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

Latest ICB Performance (12 months to Oct-24) **829** National Ranking **38/42**

Provider Breakdown (rolling 12 months to Oct-24)



Issue

- Majority of C&M trusts are above agreed trajectories for these HCAI based on improvements required from previous baselines. The provider HCAI rates are also considered in relation to the size and nature of their organisation leading to outlier alerts, benchmarked data currently available (Q2 data) shows there are three low outlier alerts for C. Diff involving East Cheshire, Mid Cheshire and Mersey and West Lancashire Trusts, despite being over tolerance and one high outlier alert for Wirral University Teaching Hospital NHS FT. Within the data for E.coli during Q2, there are no outlier alerts.
- The ICB position has not yet breached the annual tolerance but is likely to breach for CDI in December data and for E.coli in Q4.

Action

- There is a generic focus on core measures to reduce HCAI across all providers with place-based teams seeking routine assurance against key actions.
- Additional actions are being implemented for all providers with high outlier positions both to understand and tackle risk.
- Place-based teams are seeking to understand positive learning from providers with low outlier positions.
- An ICB IPC central assurance group has been established to enhance scrutiny in this area.

Delivery

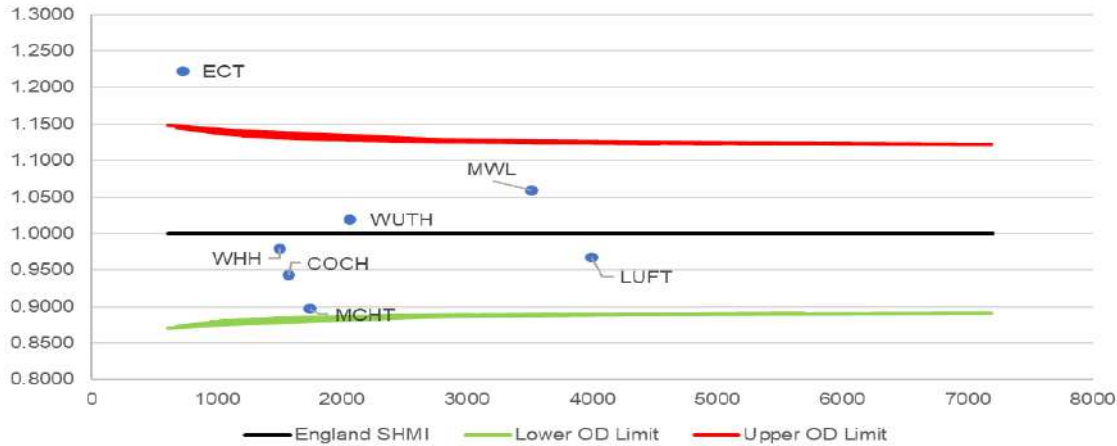
- The November position of 100 CDI (all type) is in line with previous months YTD ranging from 98 to 119 cases. The November E.coli position of 177 (all type) is the lowest YTD ranging from 177 to 227 cases per month.

5. Exception Report – Quality

Summary Hospital-level Mortality Indicator (SHMI)

Latest ICB Performance (Jul-24) **0.991** National Ranking **n/a**

Provider Breakdown (Jul-24)* **Improved**



Issue

- C&M trusts are within expected tolerances except ECT, with a current value of 1.2248 against the upper control limit for ECT of 1.1445.

Action (ECT only)

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

Delivery

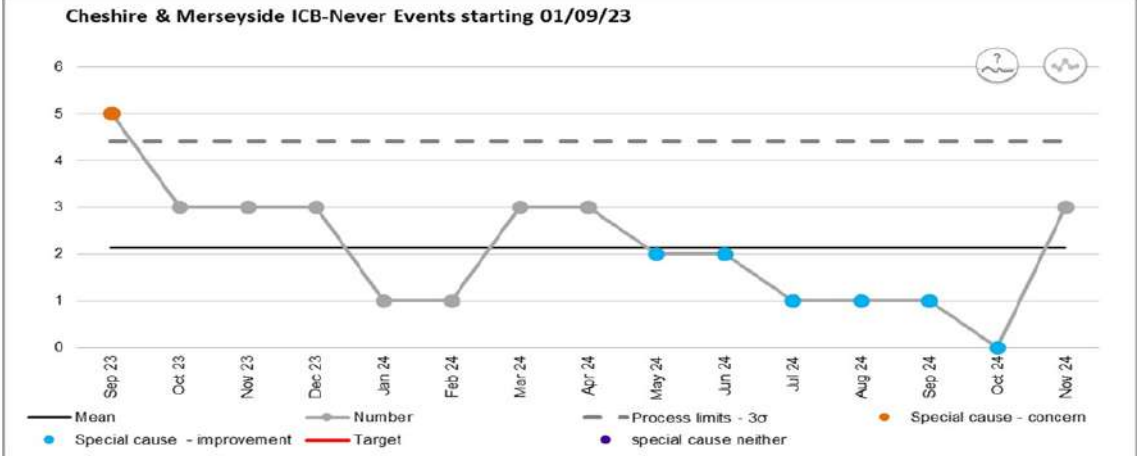
- Some CRAB metrics have shown positive improvement, although not yet defined as sustained.
- The improvement culture in the trust is palpably improved and a Board to Board review in November has led to next steps including a review using HSMR+ that brings more sophisticated analysis including the impact of frailty – a significant issue in this population.

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

Never Events

Latest ICB Performance (Nov-24) **3** National Ranking **n/a**

ICB Trend (Nov-24) **Deteriorated**



Issue

- C&M have had 21 Never Events over the last 12 month rolling period, which is a reduction from 31 during the previous 12-month period. The above chart had demonstrated special cause improvement over the past 6 months, however three Never Events were reported during November 24. Whilst this is above average, one of the events reported relates to an incident from 2020 involving retained product that has only been identified and reported this month. The other two events were wrong site invasive procedures.

Action/s

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

Delivery

- There have been 3 Never Events during the first part of Q3 and likely to remain below mean for previous 12 months.

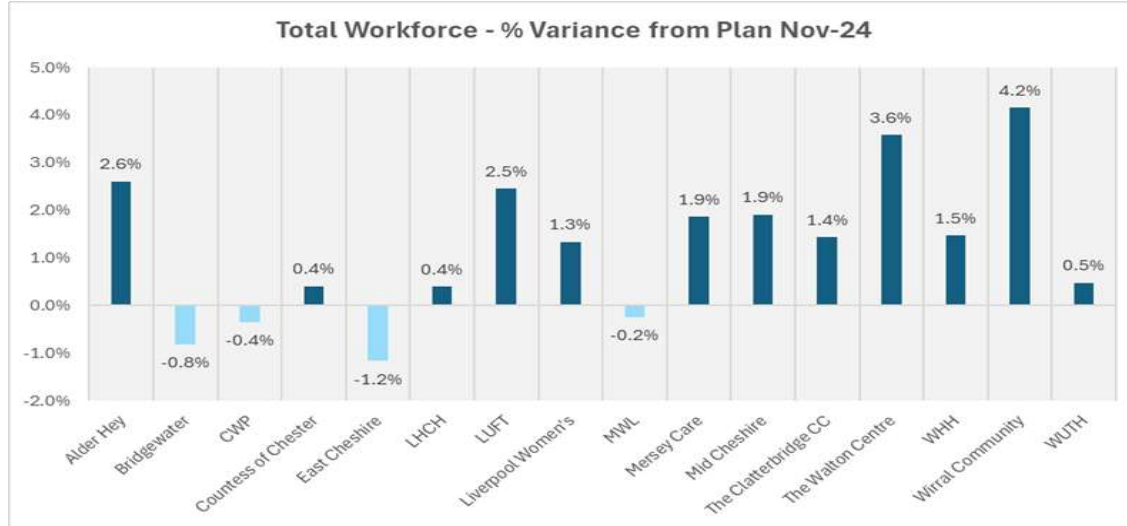
5. Exception Report – HR/Workforce

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

C&M ICB Performance (Nov-24)

1.3%

Provider Breakdown (Nov-24)

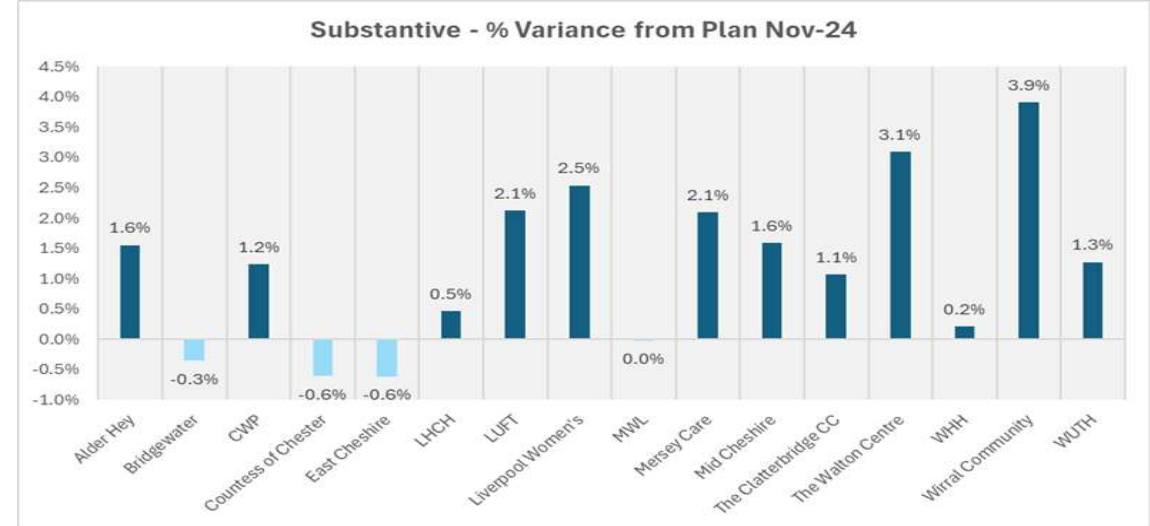


Substantive Variance from Plan % - via PWRs

C&M ICB Performance (Nov-24)

1.2%

Provider Breakdown (Nov-24)



Issue

- In Nov-24, fourteen of the sixteen C&M Trusts reported their total workforce WTEs were above their plan as at M08, with a C&M variance from plan of +1.3% (999.4 WTE).
- Thirteen of sixteen C&M Trusts reported substantive staff in post numbers higher than that forecast in their operational workforce plans (as re-submitted on 4th October 2024). The total system performance was a variance from plan of +1.2%.
- At system level, substantive staffing increased by 167.7 WTE / 0.2% from the previous month – with increases across all but four Trusts.

Action

- Commentary was requested & received from Trusts to explain the WTE increase above plan, with key themes linked to recruitment of newly qualified staff (planned); safe staffing to match patient acuity & offsetting preceptorship / training time against service delivery
- All Trusts have in place vacancy authorisation processes. Greater scrutiny of workforce and pay costs data at organisational and system level is now taking place – on a weekly basis. The workforce WTE monitoring dashboard is shared with Trusts monthly – for review and feedback; where individual performance can be interrogated in terms of WTE numbers & assumptions for the coming quarter / financial year.

Delivery

- C&M FICC (Financial Incident Command Centre) was stood up on the 8th Oct-24; all Trusts required to submit weekly workforce WTE for their total workforce & cost improvement plans progress.
- Proactive monitoring of workforce data & proposed actions now takes place with Chief People Officers as part of monthly assurance meetings & C&M Trust PDN Network focussed workstream.

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

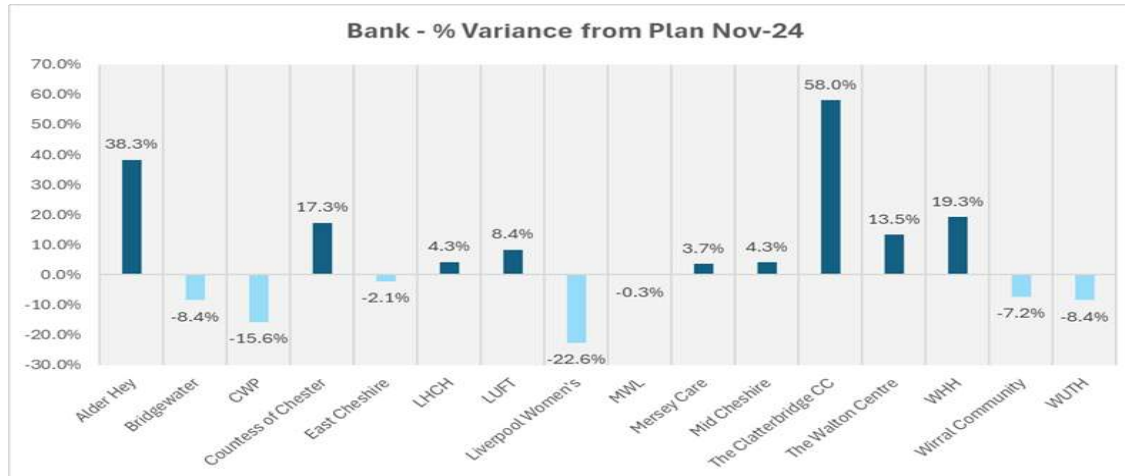
5. Exception Report – HR/Workforce

Bank Variance from Plan % - via PWRs

C&M ICB Performance (Nov-24)

4.2%

Provider Breakdown (Nov-24)



Issue

- Twelve of sixteen C&M Trusts had Bank usage higher than that forecast in their operational workforce plans during Nov 24. The total system performance was a variance from plan of +4.2%
- Comparatively at a system level, the total bank usage decreased by -219.5 WTE / 4.3% from the previous month.

Action

- All Trusts are reviewing their internal workforce resourcing processes & specific organisational actions Temporary staffing data (WTEs Utilised and Rates Charged) is a continued focus for all Trusts.

Delivery

- The C&M FICC (Financial Incident Command Centre) was stood up on the 8/10/24; all Trusts are required to submit weekly workforce WTE agency for their total workforce WTE – with an additional ask around Bank & Agency rates.
- Proactive monitoring of workforce data & proposed actions with Chief People Officers as part of monthly assurance meetings & C&M Trust PDN Network focussed workstream will resume in Jan-24.

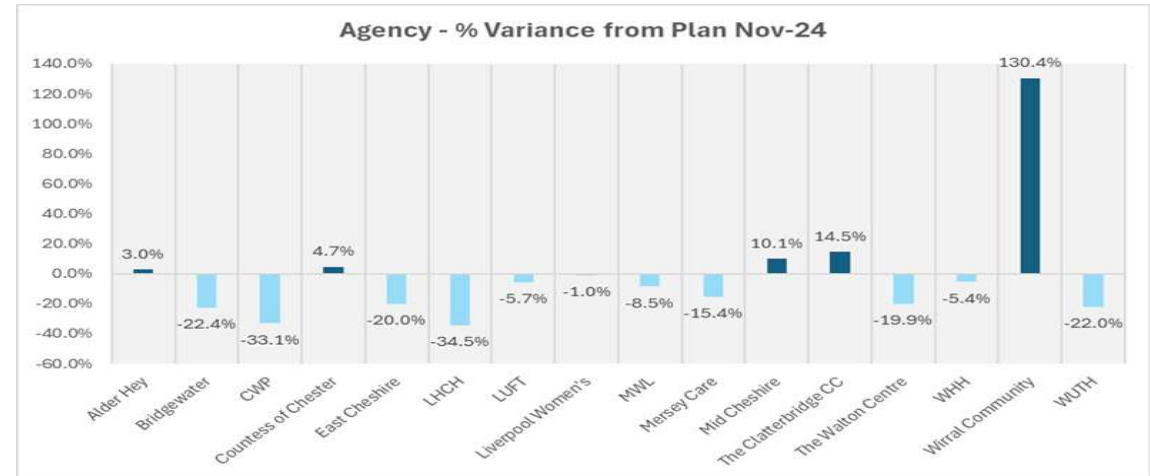
Please note that the WTE operational plan figures were re-forecast for M5 to M12 24/25, following a request from NHSE for risk-adjusted financial plans to the end of the year.

Agency Variance from Plan % - via PWRs

C&M ICB Performance (Nov-24)

-10.4%

Provider Breakdown (Nov-24)



Issue

- Nine of sixteen C&M Trusts had Agency usage higher than that forecast in their operational workforce plans for the month of November. However, the total system performance was a variance from plan of -10.4%
- At system level, Agency usage decreased by -121.8 WTE / 12.1% from the previous month.

Action

- Temporary staffing data (WTEs Utilised and Rates Charged) are being reviewed across all Trusts.

Delivery

- Proactive monitoring of workforce data now takes place with Chief People Officers as part of monthly assurance meetings.
- Proactive communication to Chief People Officers, Workforce & Resourcing Teams about Off-Framework and Agency Spend data (by staff group) is shared monthly.

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

5. Exception Report – Finance

Overall Financial position Variance (£m)

Latest ICB Performance (Nov-24) **-67.4** National Ranking **n/a**

Provider Breakdown (Nov-24)



Issue

- The ICS reports a YTD deficit of £129.5m as at Nov-24 which represents a £67.4m adverse variance to plan. Within that, the ICB position is a YTD surplus of £0.8m which is an adverse variance of £40.7m compared to the £41.5m YTD surplus plan.
- ICB pressures are linked to CHC, MH packages of care and prescribing. During the month the ICB has recognised costs within the position that were previously held as risks.
- The adverse variance on provider positions (£26.7m) is driven by industrial action and associated lost income, undelivered CIP, ERF underperformance, costs associated with the Thirlwall Inquiry and the Wirral Cyber attack.
- The net unmitigated ICS risk was reported at month 8 as £75.7m (£32m ICB and £43.7m providers) – no material overall change in-month.

Action

- Investment decisions to be taken to improve position non-recurrently.

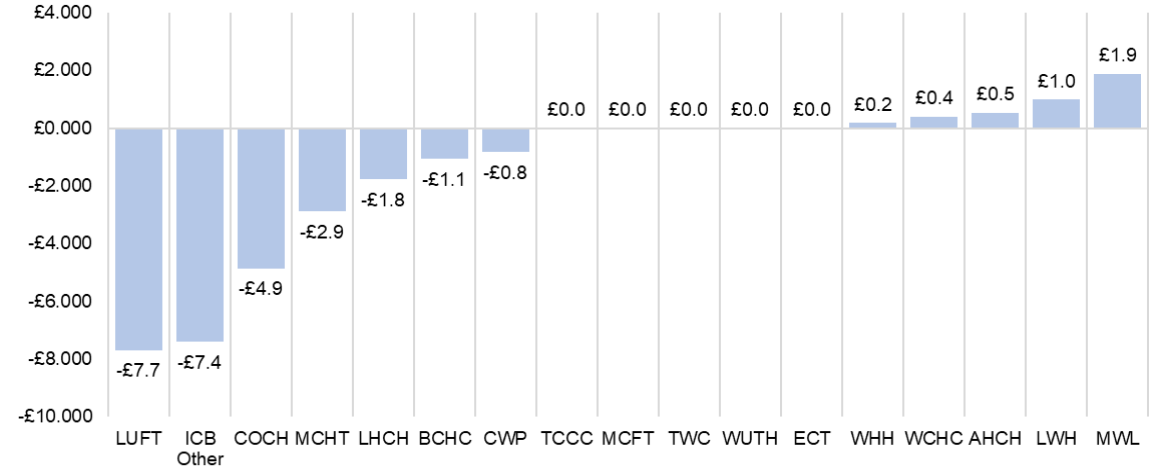
Delivery

- System reported a forecast in-line with plan to NHSE for M8. However, the £75.7m net risk must be mitigated to deliver the planned position.

Efficiencies Variance (£m)

Latest ICB Performance (Nov-24) **-22.5** National Ranking **n/a**

Provider Breakdown (Nov-24)



Issue

- ICS efficiencies - £235.3m achieved as at M8 – a £22.5m shortfall against the plan and a contributory factor to the YTD adverse variance reported.
- System is forecasting that it will deliver £437m of the £440m efficiency target - as part of the requirement to deliver the overall financial plan for the year therefore an improvement in the run-rate of savings is required in the remaining months of the year.
- Recurrent Efficiency plans are forecast to slip by £109.2m primarily due to provider organisations – to be largely offset through non-recurrent measures for this year.

Action

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

Delivery

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

Meeting of the Board of NHS Cheshire and Merseyside

Highlight report of the Chair of the Quality & Performance Committee

Agenda Item No: ICB/01/25/10

Committee Chair: Tony Foy
ICB Non-Executive Member



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Highlight report of the Chair of the Quality & Performance Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date(s) of meeting	12 December 2024 7 09 January 2025

Key escalation and discussion points from the Committee meeting

Alert

Safety

Incidents reported on STEIS relate to Speech and Language Therapy services at East Cheshire Foundation Trust – harm caused by delayed assessment. The Trust is carrying out a thematic review and has had support from ICB colleagues in terms of developing additional key lines of enquiry. This concern will also be put on the SHMI meeting agenda. An update will be provided to QPC in February.

Merseycare (Byron Ward)

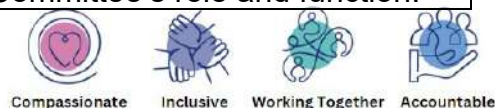
Byron Ward has been in business continuity throughout the last year, with a Trust risk score of 20. This is due to; Staff sickness, Staff vacancies, specifically registered nurses, increased incidents including safeguarding concerns and acuity of ward.

Notification was received on the 19th of December 2024 that the Trust had made the decision to temporarily close Byron Ward with immediate effect. This decision was made due to increased risk, with the business continuity level increasing to level 2 due to staffing being less than 50% and having only one Registered Nurse and safeguarding issues. As a result of the contributory factors related to ward closure and risks identified, the ICB has enacted a meeting of its Emerging Concerns Group, in line with its agreed quality governance processes.

Terms of Reference Review

The Committee reviewed its Terms of Reference (TOR) at the annual review of its effectiveness and made material changes to Section 4, 7 and 10 of the TOR which respectively describes its Membership, Quorum and Reporting and Accountability Arrangements, changes made are outlined below.

- the committee agreed to include an explicit reference to those officers classed as 'Regular Attendees'.
- the committee agreed to remove reference to Partner Members fielding 'Deputies' as this was impractical.
- the committee agreed to change the reference to Lay Member attendance and replace with Health Watch as regular attendees.
- the committee agreed to changes to the Quorum arrangements; changing from three Board members (one Non-Executive Director to Chair, the Executive Director of Nursing & Care and Medical Director) to 50% of the membership (5) being present, which is to include at least 1 clinical member and 1 Non-Executive Director to act as Chair.
- the committee agreed to removal of the reference to the Committee submitting reports being made to satisfy any requirements in relation to disclosure of public sector executive pay, as this was not aligned with Committee's role and function.



Recommendation:

The Board is asked to approve the proposed changes to the Quality and Performance Committee Terms of Reference (Appendix One)

Advise

Learning from Lives and Deaths – People with a Learning Disability and Autism Performance Pressures

There continues to be a significant backlog of reviews carried over from CCGs.

- the team (reviewers for GM and C&M) has operated at reduced capacity since the service was implemented. The team is currently 2.2 WTE below establishment. The reduced capacity does not enable the service to meet demand, and it continues to run with a backlog of reviews.
- a challenge exists for the service as any backlog impacts upon the compliance towards the current KPI that requires 100% of all reviews to be completed within 6 months of notification of the death into LeDeR.
- further work is on-going to ensure all in-depth reviews have key lines of enquiry to guide the scope to enable a proportionate quality review. The team continue to work to business-critical functions only to maximise capacity.

Hospice Provision

The report covered the 11 adult hospices, 1 children’s hospice and 1 infant/baby hospice within the system. Also noting a further three hospices close to the borders of C&M where some patients may attend.

- the paper identified variation within funding arrangements; all hospices rely on additional charitable funds to deliver their services, (with available data indicating between 16% and 61% of expenditure supported by NHS Funding. These services vary and are mostly limited-service specifications allowing hospice provision to fluctuate without contractual oversight.
- the quality oversight arrangements with the ICB are largely voluntary and quality schedules are accepted by each hospice as a negotiated position rather than contractually required (at least for core services supported by the grant funds). Through quality meetings, ranging from quarterly to bi-annually, there are no significant concerns with the care provided within the hospices, but it is widely recognised that service provision can be fragile within this sector.

The committee requested additional assurance at future meetings through Place reports and consideration in the commissioning intentions programme.

Maternity

LMNS recommendation that East Cheshire Trust to be incorporated into Cheshire and Merseyside LMNS system supported.

Assure

Maternity

- an update on Liverpool Women’s Hospital (LWH) compliance with Element 4 was requested by QPC in November re Effective Fetal Monitoring during Labour of the Saving Babies Lives Care Bundle. It showed,
 - Training shows a variation across professional groups against the 90% standard, only Midwifery fully compliant – compliance across all groups expected by end November.
 - Risk Assessment of Labour onset – fully compliant.

- 'Fresh Eyes' (continuous fetal heart rate monitoring - hourly peer review) – continuous improvement noted, up to 74% by June against the 80% standard
 - Maternal and fetal wellbeing – fully compliant
 - during Quarter 2 24/25, nine diverts have been reported for Warrington and Halton, representing the highest number of diverts for any one provider over a 12-month period. After Action Reviews are currently going through Trust governance.
 - C&M is performing well against most of the metrics (derived from the Regional Maternity Dashboard)
 - 8 of the 14 measures show C&M performing better than GM and L&SC including two substantially higher than the England average (Placement on Continuity Care of Black and Asian Women and Women from Most Deprived areas).
 - Induction of Labour at 35% is a performance outlier but the committee was informed that the rate was decreasing. Discussions being held with AQUA and Innovation Agency to implement a QI programme.
- Learning Disability**
- CWP Assessment and treatment units for adults with learning disabilities have been in business continuity due to staffing levels for some time. However, the situation has improved and the risk to service has decreased, so both have now been stepped down. Quarterly site visits alongside NHSE colleagues and the ICB place team will continue.

Committee risk management

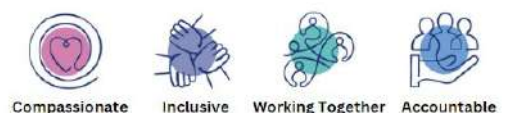
The following risks were considered by the Committee and the following actions/decisions were undertaken.

Corporate Risk Register risks	
Risk Title	Key actions/discussion undertaken
QU04 – Safeguarding (recruitment): ICB SCORE 8 QU05 – Neurodevelopmental (ASD/ADHD) assessments: ICB SCORE 20 QU08 Standards of Care	Reviewed Place risk scores – some increased to 16 (Cheshire East and Liverpool) Noted Sefton increased score – Wirral decreased score Risk descriptor reviewed and split into 'lack of Quality staff' and 'oversight processes'.

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Urgent and Emergency Care	Understanding collective risks
Maternity	Improving Assurance against Standards



NHS Cheshire & Merseyside ICB

Quality & Performance Committee

Terms of Reference
v0.9

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Document revision history

Date	Version	Revision	Comment	Author / Editor
13.04.22	0.1	ICB Quality Committee	Initial Draft	Michelle Creed
11.05.22	0.2	ICB Quality Committee	Revision consultation comments	Michelle Creed
18.05.22	0.3	ICB Quality Committee	Revision consultation comments	Ben Vinter
07.06.22	0.4	ICB Quality & Performance Committee	Revision to include Quality & Performance	Ben Vinter
09.06.22	0.5	ICB Quality & Performance Committee	Revision consultation comments	Michelle Creed
31.07.23	0.6	ICB Quality & Performance Committee	Revision consultation comments	Kerry Lloyd
12.09.24	0.7	ICB Quality & Performance Committee	Revision consultation comments	Kerry Lloyd
12.09.24	0.8	ICB Quality & Performance Committee	Revision post QPC review	Kerry Lloyd
26.09.24	0.9	ICB Quality & Performance Committee	Revision post QPC review	Tony Foy

Review due: August 2025

1. Introduction

The Quality & Performance Committee (the “Committee”) has been established in accordance with the Integrated Care Board’s (ICBs) constitution.

These terms of reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee 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.

2. Role and Purpose

The Quality and Performance Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centred, well-led, sustainable and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This includes reducing inequalities in the quality of care, coupled with a focus on performance.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

The committee will focus on quality, performance data and information and consider the levels of assurance that the ICB can take from performance oversight arrangements within the ICS and actions to address any performance issues.

The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit:

Quality

- Ensure that there are robust processes in place for the effective management and consideration of quality, safety, and patient experience.
- Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern
- Oversee development of the ICB’s key quality priorities, including priorities to address variation/ inequalities in care, and recommend these priorities to the ICB for inclusion in the ICB Strategy / Annual Plan
- Oversee and monitor delivery of the ICB key statutory requirements
- Review and monitor those risks on the BAF and Corporate Risk Register which relate to quality, and high-risk operational risks which could impact on care.
- Oversee and scrutinise the ICB’s response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best



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practice as issued by the DHSC, NHSEI and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained

- Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites
- Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programs
- Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place
- Ensure processes are in place to enable the ICB to identify lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded
- Ensure that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD reports)
- Ensure that mechanisms are in place to systematically and effectively involve people that use services as equal partners in quality activities
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people using commissioned services
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety

Performance

- Receive, review, and scrutinise the integrated performance reports for the ICB with a focus on quality, safety, patient experience and outcomes.
- Ensure that contract quality performance is monitored in a way that is proportionate to risk
- Identify and scrutinise significant variations from plan of all Key Performance Indicators (KPIs)
- Scrutinise the appropriateness and robustness of any management actions to address identified performance issues in relation to the quality of services.
- Ensure actual and forecast contract over-performance or under-performance is quantified in financial terms and activity terms
- Benchmark recovery plans against trajectories
- Agree which of the underperforming contracts need to be brought to the attention of the ICB
- Ensure the implementation of the priorities set out in the Operational Planning Guidance
- Oversee the ongoing delivery of procurements and any major service change, with a focus on quality, safety and patient experience in line with statutory requirements.



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- In relation to quality of services, seek assurance that the procurement of services is consistent with relevant laws and that conflicts of interest have been declared, managed and published as required.

In particular, the Committee will provide assurance to the ICB on the delivery of the following statutory duties:

- Duties in relation children including safeguarding, promoting welfare, SEND (including the Children Acts 1989 and 2004, and the Children and Families Act 2014); Working Together to Safeguard Children (2023) and;
- Adult safeguarding and carers (the Care Act 2014).

To deliver this, the responsibilities of the Committee will include:

- Ensuring the ICB is informed in a timely manner of significant risks, issues and mitigation plans relating to quality and performance (in line with the remit of the Committee).

3. Authority

The Committee is authorised by the Board to:

- Request further investigation or assurance on any area within its remit
- Obtain such internal information as is necessary and expedient to the fulfil its functions
- Undertake, where necessary, 'deep dives' into specific issues that will enable it to gain a greater level of understanding and assurance into specific issues that fall 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
- Escalate issues to the ICB
- Produce an annual work plan to discharge its responsibilities
- Approve the terms of reference of any sub-groups to the committee (e.g. System Quality Groups, Infection Prevention and Control, Local Maternity and Neonatal System, SEND Partnership Boards)
- Delegate responsibility for specific aspects of its duties to sub-groups. The terms of reference of any sub-groups shall be approved by the Committee.

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 and Attendance

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

Membership of the Committee may be drawn from the ICB Board membership; 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.

The Committee members shall be:

- Non-Executive Member of the ICB (Chair)
- Non-Executive Member of the ICB (Deputy Chair)
- ICB Director of Nursing & Care
- ICB Medical Director
- ICB Director of Performance and Planning
- Up to two ICB Partner Members
- 2 Patient Safety Partners – TBC

Regular Attendees:

- Assistant Chief Executive
- Healthwatch
- Place Director/s
- [Deputy Director Nursing and Care](#)
- [Associate Directors Quality & Safety](#)
- [Chief Pharmacist](#)

All Committee members may appoint a deputy to represent them at meetings of the Committee. 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 clinical members).

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

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.



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

5. Chair and Deputy-Chair

The Committee shall be chaired by a Non-Executive Member of the ICB. The Deputy Chair shall be a Member of the ICB.

If the Chair, or Deputy Chair, is unable to attend a meeting, they may designate an alternative ICB member to act as Chair.

If the Chair is unable to chair an item of business due to a conflict of interest, another member of the committee will be asked to chair that item.

6. Meetings

The Committee will meet in private.

The Committee will generally meet monthly and arrangements and notice for calling meetings are set out in the Standing Orders.

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

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

7. Quorum

A meeting of the Committee is quorate if 50% of the membership (5) are present, to include at least 1 clinical member and 1 Non-Executive to act as

8. Decision-making and voting

Decisions should be taken in accordance with the Standing Orders.

The Committee will usually make decisions by consensus. Where this is not possible, the Chair may call a vote.

Only voting members, as identified in the "Membership" section of these terms of reference, may cast a vote.

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

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



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

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

9. Administrative Support

The Committee shall be supported with a secretariat function. Which will include ensuring that the agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.

Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.

Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.

The Chair is supported to prepare and deliver reports to the Board.

The Committee is updated on pertinent issues/ areas of interest/ policy developments; and action points are taken forward between meetings.

10. Accountability and Reporting Arrangements

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

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board.

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

11. Behaviours and Conduct

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.

All members shall comply with the ICB's Managing Conflicts of Interest Policy at all times. In accordance with the ICBs' policy on managing conflicts of interest, Committee members should:

- Inform the chair of any interests they hold which relate to the business of the Committee.
- Inform the chair of any previously agreed treatment of the potential conflict / conflict of interest.



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

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

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

Equality diversity and inclusion

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

12. Monitoring Effectiveness and Compliance with Terms of Reference

The Committee will review its effectiveness at least annually

13. Review of Terms of Reference

These terms of reference will be reviewed at 12 months in August 2025/26 and thereafter at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.



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Meeting of the Board of NHS Cheshire and Merseyside

30 January 2025

Report of the ICB Directors of Place

Agenda Item No: ICB/01/25/11

Responsible Director: Deborah Butcher (ICB Place Director – Sefton)
Anthony Leo (ICB Place Director – Halton & Liverpool)



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Report of the ICB Directors of Place

1. Purpose of the Report

- 1.1 The purpose of the paper is to provide Board members with an overview of key areas of focus and delivery being undertaken at Place within the Integrated Care System.
- 1.2 The paper provides insight into the activities of each place, based on these agreed key themes and areas of focus.
- 1.3 This paper is a regular update to the Board with regards to Place work, providing assurance to the Board on how teams are working towards the delivery of the Integrated Care System (ICS) objectives by working with partners locally to improve health and wellbeing of local population.

2. Executive Summary

- 2.1 This report provides an overview of activities being undertaken at Place level describing the arrangements which support the Integrated Care Board (ICB) strategic priorities.
- 2.2 The report provides further detail on key aspects of each Place's operational activities describing key features where local teams work in partnership with partners and stakeholders in support of delivery of the organisations objectives.
- 2.3 Further insight is provided within the report across focus areas including place partnership development, place risks, action on health inequalities, patient discharge and flow, primary care network development, provider market development, strategic issues as applicable to each place, children and young people's issues and use of resources.

3. Ask of the Board and Recommendations

3.1 The Board is asked to:

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



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4. Place Partnership Development

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

4.1 Cheshire East

Our most recent Place Partnership Board was held in early November. Our agenda included – as always – celebrating the work of one of our excellent care communities. This time it was Nantwich and Rural.

We have a developed performance dashboard with key metrics for urgent and emergency care. We are starting to use this information, and also to develop stronger accountability for performance.

Key items on the agenda included using population health data to identify specific patient cohorts e.g., frailty and identify local health interventions and sharing specific proposals for Cheshire health and care transformation.

4.2 Cheshire West

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

An update on a proposed Joint Intelligence Board across Cheshire West & Chester was presented to Place Committee in January 2025, which was strongly supported by members as an opportunity to make the most of the available capacity and expertise as well as more effective prioritisation.

Community Partnerships are one of the key workstreams and form the delivery foundation of our Joint Transformation Programme work - now led by the Third Sector via Cheshire West Voluntary Action (CWVA). Work had been taking place throughout autumn 2024 to evidence and celebrate the successes that Community Partnerships have already achieved.

At the January 2025 meeting, the Committee received an update about the impact of the Neston / Willaston Community Partnership working in collaboration with Cheshire Community Action and Wirral Age UK across the 'border' for patients admitted from Neston /Willaston into Arrowe Park which led to delayed discharges. This influenced the expansion of the Community Connector role (secured through charitable funding) to enable faster discharge for those needing some additional support but equally importantly providing opportunity to connect individuals into ongoing voluntary sector support such as befriending services. These updates will now form a standing agenda item on Place Committee meetings. It was also agreed that sustainable funding for this project would be explored. Further spotlights from Community Partnerships will be provided at future meetings.

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

4.3 Halton

Following on from the last One Halton Partnership Board meeting, the Board has considered proposals for the progression of One Halton programmes for Starting Well, Living Well, Ageing Well and Wider Determinants with a view to a more focused approach on a smaller number of key deliverables; given the context of system-wide financial challenges and on-going work by partners in supporting the ICB-wide Recovery Programmes.

Looking ahead, the next Board session will focus on:

- “Data into Action” and its application in supporting the delivery of local priorities
- Next steps for the further development of the Integrated Neighbourhood Model in Halton
- Progress update on Same Day Access to Primary Care
- Progress update on Long Term Condition Management.

4.4 Knowsley

The Board is in recess for December and January to support the focus on winter pressures. The next meeting is scheduled for February 2025.

4.5 Liverpool

The One Liverpool Partnership Board last met on 11th December 2024. The Board received an update on the Liverpool City Council CQC inspection, which focused on the whole adult care system. Mersey Care also gave feedback to the Board on the future development of its ‘Life Rooms’ project, which partners agreed should consider the relationship / links to neighbourhood services provided by the local NHS and Liverpool City Council. A further update on the Liverpool Health and Wellbeing Board review by the Local Government Association (LGA) was provided by the Director of Public Health, for which partners had been contacted to participate in interviews to take place in January 2025.

4.6 St Helens

The St Helens Place Partnership Board continues to meet on a monthly basis. The membership continues to evolve and now includes Headteacher representatives, multiple voluntary sector partners in addition to Health and Care representatives (including Local Councillors).

4.7 Sefton

The partners in Sefton continue to work collectively in response to the Southport Major Incident. The extensive multiagency response and recovery cell remains in place with the ICB leading on the activation of the Cheshire and Merseyside Psychological Support Plan Following a Major Incident, led by the ADQSI for Sefton Place. Support is available via the local authority website ‘Southport Together’ which includes the emotional and mental health offer of



support <https://www.sefton.gov.uk/southport-together/>.

A learning event was held on 4th December 2024 for members of the psychological care co-ordination group and case workers delivering direct support to victims and witnesses to build on learning to date, and inform the emergency, preparedness, resilience, and response (EPRR) and psychological response planning, including support for group members directly involved.

A rapid review has been submitted for the suspected perpetrator and a local child safeguarding practice review (LSCPR) will be commenced by Lancashire Safeguarding Partnership as agreed by the National Panel. Sefton are working in partnership to ensure all services involved from Sefton are contributing to processes. A multiagency action plan has been developed to support immediate agency learning emerging from the Rapid Review. The court hearing for the young person is due in January 2025.

4.8 **Warrington**

Warrington Together Partnership Board's recent meetings have received updates on the following topics:

- Utilisation of Discharge to Assess Beds
- Hypertension pilot project
- Warrington Pharmaceutical Needs Assessment 2025-2028
- Adult Social Care Discharge Fund for 2025/26
- Urgent & Emergency Care Recovery Programme
- Quality & Performance Committee (Risk Analysis) deep dive
- Children's Wellbeing and Schools Bill 2024
- Cheshire and Warrington Devolution.

Additionally, in November 2024 Warrington Borough Council and C&M ICB were visited by the Department for Education (DfE)/NHS England and then again in December 2024 by OFSTED to review progress against our SEND Inspection 2023 Recovery Plan.

Feedback received from the DfE/NHSE visit was positive and the OFSTED feedback has been checked for factual accuracy, and we are now awaiting the final report.

4.9 **Wirral**

Meetings of 21st November and 19th December 2024 included updates on:

- Primary Care Access Recovery Plan Update Report
- Wirral Place Review
- Place Finance Report incorporating Pooled Fund Update
- Quality and Performance Report
- Wirral Health and Care Plan Programme & Workforce Programme
- Delivery Dashboard
- Unscheduled Care Improvement Programme
- Supporting Groups Chairs' Reports.

In terms of the BCF for 2025/26, planning workshop are scheduled to agree the 25/26 commissioning intentions.

5. Place Risks and actions to address

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

Table One

Rank	Risk	Key Actions
1	Performance: Urgent care flow / no criteria to reside	Current controls include daily collaborative discharge monitoring and escalation, system winter plans and additional capacity, and admissions avoidance services. Further action and initiatives are being developed and progressed through the urgent care recovery programme.
2	Quality: Neurodevelopmental assessment delays	Current controls include the assessment framework, performance monitoring of commissioned providers, clinical networks, SEND improvement plans, and quality and performance reporting. Key further action underway to develop joint and strategic approach to commissioning for Autism and ADHD.
3	Quality: Reduced standards of care	Current controls include key policies and standards, incident reporting and harm review process, standard contracts, System Quality Group, and quality dashboard reporting. Key further actions planned include development of UEC patient safety principles, development of primary care quality forum and strengthening of host commissioner arrangements.
4	Quality: Safeguarding Services capacity	Current controls include working across place footprints and prioritising statutory duties. Key further action includes the commencement of a talent pipeline / career path for Designated Nurses.
5	Finance: Cost pressures driving overspends and / or inability to deliver efficiency improvements	Current controls include delegated budgets, budgetary control and expenditure approvals process, financial recovery plans and efficiency schemes, programme and project management, monitoring, and reporting. Key further action is being taken to address cost pressures in relation to CHC and prescribing, and to develop longer-term financial plans delivering recurrent efficiencies.

- 5.2 The scoring and distribution of significant common risks across the 9 Places is illustrated in the heat map (Figure One) and may indicate where further action is required in a particular place/s to strengthen the effectiveness of an existing control or to implement additional controls.
- 5.3 In addition, there is a significant risk in Halton and Wirral that the health and care system is unable to meet the needs of children and young people with complex and/or additional needs leading to long term health issues, increased inequalities and demands on services, currently rated as extreme (16).

Figure One

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

6. Action on Health Inequalities at Place

6.1 Cheshire East

Planning is underway on the allocation of health inequalities funding approved at the September 2024 ICB Board.

6.2 Cheshire West

The Cheshire and Merseyside Health Inequalities fund is being utilised to support Mental Health and crisis interventions for Children, Young People, and their families. In addition, a new programme of work has been stepped up to work across place partners to carry out joint interventions to improve Primary, Secondary and Tertiary prevention of cardiovascular diseases. This work will focus primarily on those communities/cohorts facing the biggest health inequalities.

6.3 Halton

Work is ongoing to develop a Poverty Truth Commission (PTC) for Halton. A wide range of One Halton partners are engaged and supportive of the initiative. Progress has been slightly delayed due to holdups in processing funding applications by the Legal & General Health Equity Fund. Halton is currently awaiting the outcome of a £75,000 application, with applicants expected to be informed by the end of January. Additionally, Halton partners have submitted a £5,000 application to the Poverty Truth Network for a PTC development grant. If successful, this funding will be used to raise awareness of the project and identify Community Commissioners – local people with lived experience of poverty.

Halton's 'Core20PLUS5' Connector Project continues to receive high praise and has been invited by NHSE to present at the Royal Society of Medicine's "Tackling Health Inequalities: Health is Wealth" conference on January 28th 2025. Three representatives – a Connector, a Voluntary Sector partner, and the NHS Project Lead – will host a round table discussion about their work. Halton's Connectors are currently involved in various projects, including the development of a 'Connector Garden' at the rear of a local community centre. The National Gardening Scheme has agreed to fund the project, and our Core20 Connectors are busy developing plans. Connectors are also supporting the development of a gentle exercise class at Murdishaw Doctors' Practice. Supported by the local authority Sports Development Team, the class is free to participants and aims to target patients with high blood pressure who may struggle to afford class costs or do not feel comfortable exercising in a more public setting. The classes are set to launch at the end of January 2025.

6.4 Knowsley

Severe Mental Illness (SMI) Health Checks - the Mental Health Long Term Plan requires that people with Severe Mental Illness receive an annual physical health check. Knowsley's SMI Health Check rate improving from 42.6% in April 2024 to 52.6% in December 2024. There have also been improvements in rates of dementia diagnosis - from 59.7% to 62.9% between November 2023 and November 2024.

Adult Attention Deficit Hyperactivity Disorder (ADHD) – Mersey Care FT has taken a proactive review of the current pathway with ICB colleagues, due to increased referrals into the service, which is approximately 600% above commissioned levels. This will include an updated referral pathway, supporting those individuals where there is clear evidence that their day-to-day functioning is affected by presenting symptoms. Some of those symptoms may be supported through psycho-social education and intervention from existing services such as Talking Therapies/Mental Health services or third sector support. Others may require a formal assessment and diagnosis which could include medication. GPs have been able to refer into the ADHD service from October 2024.

6.5 **Liverpool**

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

At the time of writing, 75 of 82 eligible Liverpool General Practices have signed up to deliver the Primary Care Local Quality Incentive Scheme (LQIS) for phlebotomy. Further work is also taking place to ‘activate’ and develop links between the AED Frequent Attenders Review Group and ICCT Proactive Care Multi-Disciplinary Team, whilst 36 ‘revolving door’ patients have recently been identified with the aim of improving their care pathways and care experience during the winter period.

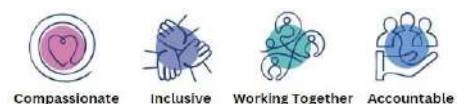
Developments in relation to digital initiatives since the last report include:

- Blinx PACO Pilot: - Liverpool pilot practices have been working towards technical enablement, attending Blinx PACO Boot Camps and completing online training.
- ORCHA (Health & Care apps) – downloadable ‘heart health apps’ launched, which could be indicative of the engagement with Cardiac Rehab Team at Aintree. Over 2,000 individual hits have been recorded on the ORCHA website in December 2024
- Shared Record - an engagement & awareness session with the Connected Care Record Programme has been arranged for the Liverpool Place team on Tuesday 14th January 2025.

6.6 **St Helens**

CGL service have produced an incredibly powerful and moving film “Sticks and Stones,” in which they discussed their own lived experiences of stigma. By supporting these marginalised groups to take centre stage, we are already helping to overcome the barriers that stigma might otherwise create.

Building on this, and supported by IVAR, the Inequalities Commission arranged a Tackling Stigma Workshop. This was attended by 65 system leaders from health, social care, VCSFEs and the local authority, as well as people with lived experience whose insights were recognised to be so integral to any meaningful strategy development. Together with another viewing of Sticks and Stones, the Anti-Stigma Charter was further promoted, and opportunities for reflection led to



action planning on how we can induce real system change to tackle stigma across St Helens.

The impact of this work can already be seen in the way that local partners and stakeholders have been galvanised into action on this crucial topic. “Sticks and Stones,” and reflections from the workshop, have been shared at both the St Helens Health and Wellbeing Board and NHS Place Based Partnership Board, and from there forwarded to St Helens College to support in the education of students, and the St Helens Wellbeing Service to promote the message to their staff. The Merseyside Police and Crime Commissioner has championed our work as an example of good practice at the Merseyside Combatting Drugs Partnership, and the Regional Office for Health Improvement and Disparities shared the film with north west Directors of Public Health; adopting stigma as a key priority for tackling issues around drugs and alcohol.

Following our combined efforts on delivering the Tackling Stigma Workshop, IVAR produced their first blog on the impact of stigma on health inequalities, the importance of leaders recognising and challenging stigma, and how we can lead by example, building relationships with our marginalised communities and co-creating solutions with them. Finally, Leader of the Council Anthony Burns presented both the film and a case study of Inequalities Commission work at a recent Local Government Association event, which was described as ‘thought-provoking’ by those in attendance.

The influence of this work continues to grow, with a request from the Department of Work and Pensions to share the film, and further plans for more events in the new year.

6.7 Sefton

The place team are now focusing on the national evaluation and information relating to the positive impact of the National Hydration Pilot to share across the ICB.

There is growing evidence of the impact of effectiveness of the Cheshire and Merseyside hydration pilot model of training for care home staff including preventing urinary tract infections (UTIs) with a notable drop in hospital admissions from care homes relating to UTI’s and falls. There has also been a reduction in antibiotic use in over 65 population.

Updates relating to mental health support and integration include;

- currently within Sefton we average approximately 6 patients per week who are deemed Clinically Ready for Discharge (CRFD) with Mersey Care NHS Foundation Trust (MCFT), who are reporting 80% for their provider footprint.
- Mental Health Capacity & Flow Meetings - as a system we meet on a weekly basis with MCFT, North and Mid Mersey Place representatives, LA representatives and NWS to review sitrep data and support the Trust in accelerating patient discharges where possible. This forum also enables us to identify any issues/trends that need to be addressed strategically from a place/pan-place perspective with housing/accommodation availability being a key issue. There are also MADE meetings that take place on a weekly basis with operational staff that supports patient flow also. The ICB has recently taken over chairing responsibility for these meetings, and we are starting to

evidence an increase in discharge arrangements due to the meetings being more solution focused.

- we have commissioned an integrated mental health recovery service at place (Woodlands) which provides 11 beds and 2 emergency respite beds to support timely discharge and prevent hospital admission and we are working in partnership with Sefton’s Housing Department and their Housing Options Team to further develop pathways that will support capacity and flow.

6.8 Warrington

Following approval of the Health Inequalities funding, work is progressing on the three main projects for Children- including oral health, child poverty and school readiness.

A conference is being held in on 4th February 2025 with a focus on poverty. The conference, which includes people with direct lived experience will encourage attendees to consider what actions they and their organisations can take to improve the experience of the residents of Warrington and will close with an introduction to our planned Poverty Truth Commission and completing a set of pledges for the Town.

The Targeted Lung Health Check programme continues to be rolled out, Cheshire West and Warrington Primary Care Network (PCN) was the first PCN to be included in the roll out as this has the highest areas of deprivation in the town. Central and East and East PCNs are in the second phase of the rollout and the project is progressing well.

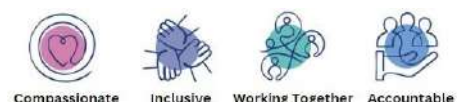
6.9 Wirral

The Core20+5 programme forms part of ‘Priority 2: Strengthen health and care action’ to address differences in health outcomes within the Borough’s Health and Wellbeing Strategy. Two workshops have been held with place partners to co-design a core set of principles that define how addressing health inequalities becomes everybody’s business and that Core20+5 is embedded across the Wirral health and care system. The second workshop looked at how to apply these principles to some specific health priorities; specifically cardiovascular disease and asthma. This has also supported the aim of bringing together the CORE20+5 work for both adults and children.

Under the Population Health Programme, there are two ‘game changers’ identified for focus - fuel poverty and the violence reduction EVOLVE Programme. Activities in these two areas include continuing to invest and develop the Fuel Poverty Services to support households, expansion of the Healthy Homes team, and in relation to the EVOLVE Programme the introduction of problem solving/implementation groups in three Wirral neighbourhoods.

A Task & Finish Group has been set up across partnership to explore how to reignite ‘Making Every Contact Count’ (MECC) principles and ensure people / workforce are supported to address local population need and priorities. A survey has gone live and aims to identify the most effective and impactful approach utilising existing Place resources and services to tackle health inequalities and the wider determinants of health.

Wirral Place is continuing to improve its performance against the national



Dementia Diagnosis rate, which in November 2024 was 67.3% (exceeding the national target of 66.7%). Work is continuing to implement the joint Dementia Strategy across the borough.

Annual Severe Mental Illness (SMI) Physical Health Checks are a clinical focus for Core 20+ 5. Wirral Place commissions Health Junction to complete the annual physical health checks and train staff within the GP practice to continue these reviews going forward. In March 2024, Wirral Place had 3326 people on the GP Practice SMI registers. Of these, 64 % (2152 people) have had an annual physical health check. This exceeds the NHS England national target of 60% compliance against with the Quality & Outcomes Framework. Before Health Junction were commissioned on Wirral the completion rate was only 13%.

Health Junction have recently completed SMI physical health checks within ST Catherine’s Surgery in Birkenhead. They achieved 73% completion rate which exceeds the national target of 60%, working towards the ambition of 75% completion rate as per the Priorities and Operational Planning Guidance 24/25.

LEAP – Adult ADHD support within Primary Care, provided by specialist GPs, is progressing well. The CWP Adult ADHD service remains closed (since 2021). Discussions are taking place with the aim of re-opening the service and, at the time of writing, we are awaiting information from CWP. All patients waiting on the list for CWP who could be appropriately supported in LEAP have been seen. Currently, CWP has 500 people on its waiting list for adults ADHD – 349 waiting (and not appropriate for LEAP as too complex), 9 transfers and then 148 transitions. We are working with WUTH and CWP CYPMHS (previously called Camhs) to improve the process for transfer into LEAP for those young people transitioning into the adult service. The CWP adult ADHD service have 748 active patients on their caseload who they are monitoring and supporting. This involves 4000 appointments a year – 1300 of which are DNAs. CWP have recently introduced a text reminder service for appointments which is sent 72hrs before the appointment to try and decrease DNAs. More GPs have been trained to diagnose ADHD and a small selection will be starting a testing period to review patients who contact the GP practice thereby reducing the need for the Right to Choose Provider. The LEAP GPs are meeting at the end of January.

The ‘Neighbourhoods Programme’ is currently on pause still since funding was withdrawn.

7. Patient Discharge and Flow

7.1 Cheshire East and Cheshire West

Following the establishment of NHS Cheshire and Merseyside’s Recovery Programme, Cheshire East and West are working together on a single Cheshire Urgent and Emergency Care Recovery Programme. The key stakeholders include the three acute Trusts, community services, primary care, NWS, Local Authorities, voluntary sector and the ICB Place teams. The programme is aligned to the three thematic areas of Admission Avoidance, In-hospital Patient Flow and Discharge (known as Home First). Good progress has been made on implementation of the Home First model, including development of an improved Discharge to Assess pathway, Discharge to Assess at Home, Virtual Wards, and UCR - all which provide better outcomes for people. Further work is underway on

preventing deconditioning within the acute Trust, addressing the variation of Length of Stay and admission avoidance projects, including high risk patient identification, and early care and discharge planning. Evaluation of the Discharge to Assess bed base performance is to be completed, with key drivers for good outcomes for people identified.

7.2 Halton

Halton continues to work in partnership with the two UEC improvement programmes within Warrington and Halton Teaching Hospitals NHS Foundation Trust and Mersey and West Lancashire Teaching Hospitals NHS Trust - focusing primarily on the admission avoidance and discharge workstreams. Halton has been working in collaboration with both systems for the 'Home for Christmas' and January 2025 recovery programmes, with additional senior social worker support on site and a focus on the rapid Pathway 1 and 2 discharges.

Non-Criteria to Reside (NC2R) remains high for the community pathways from both main acute hospitals, in line with the point prevalence activities on the wards. Additional reablement capacity has been commissioned and length of stay improvements in the community beds has increased flow, to support the higher acute discharges.

Direct referral to the intermediate teams for D2A arrangements, are now embedded for Halton patients at Warrington Hospital and being piloted at Whiston Hospital, with the aim to formalise in January 2025. There are a number of system events taking place in January to develop plans for "call before convey" and falls management to support NWAS with alternative to responding and conveying to ED.

7.3 Knowsley

Workstreams under the Mid Mersey and Lancs (MWL) Urgent & Emergency Care (UEC) Recovery Programme are progressing well in relation to flow and discharge indicators such as Length of Stay (LoS), Non-Criteria to Reside / pathways and discharges. Local Urgent Community Response (UCR) teams continue to work with North West Ambulance Service (NWAS) to increase appropriate referrals to prevent hospital attendances and admissions.

Additional discharge capacity has been created to support achieving a target of 10% non-criteria to reside (NC2R). The Knowsley data continues to show an improving position. Data quality issues remain, but the Knowsley NC2R rate is between 11-12%. Daily meetings and updates continue. We have also reviewed and 'flexed' the criteria for our Intermediate Care bed-base to include patients who have been delayed for a long-term placement or to allow home changes to be made. This has led to increased utilisation and a reduction in Pathway 2 delays.

We have also audited attendances and admissions into Whiston Hospital from Knowsley Care Homes, which has shown that a referral to UCR may have prevented admission for a significant proportion of these patients. We are working with Care Homes to provide support if there is a specific issue or a high number of ambulance calls or Emergency Department (ED) attendances. The Enhancing Health and Care Home team (provided by MCFT) have also offered 'in-reach' into

Whiston ED to support repatriation of patients to individual care homes.

The pilot within North Mersey where a member of UCR staff is present in Primary Care 24 (GP out of hours provider) to accept patients over the weekend period remains live. Data shows an increase of referrals for North Mersey at an average of 20 patients per weekend.

7.4 **Liverpool**

Despite an extremely challenging period over December 2024 with influenza hospitalisations increasing to 5.53% per 100,000 population, the North Mersey Urgent & Emergency Care (UEC) Recovery Programme has managed to maintain good progress in relation to performance against key metrics.

Length of Stay – there remains a reduction in the number of patients with lengths of stay over 7, 14 and 21 days compared to the baseline (although the number of patients with a LOS of >14 days has increased compared to the previous month). There has also been a reduction in P0-P1 delays, with sustained change management processes implemented to achieve consistent reductions in these pathways. Future focus for this programme area includes reduction of NWS handover delays across both acute sites and the completion of the MRI capacity review and the rollout of I-Refer.

Admission Avoidance – unvalidated daily operational data suggests that the proportion of NWS calls conveyed (S&C) to ED has reduced since early September, although monthly monitoring suggests that this represents a recovery of a sharp increase in S&C that occurred between December 2023 and April 2024. Other key achievements in relation to Admission Avoidance since the previous reporting period include the extension of GRACE clinic referrals to community services and finalisation of sub-contracting arrangements and potential opportunity to link the ‘Hospital at Home’ proposal by Mersey Care FT into the Virtual Ward programme.

Acute Discharge – there continues to be a reduction in the combined proportion of patients discharged to Pathways 2 and 3, and an increase in the combined proportion of patients discharged to pathways 0 and 1 (an increase from circa 91% in April 2023 to approximately 96% in the current reporting period). The proportion of patients discharged to both P2 and P3 are now approximately half the level they were at baseline. A significant volume of patients continue to be assigned to Pathway 3, whilst the numbers waiting for P3 placements (compared to the available placements) presents a significant challenge. Weekly reviews of brokerage transactions to manage P3 patients is in place, with support for those transitions provided via Mersey Care FT. For the next period, focus will be on a ‘deep dive’ into End of Life/Fast Track provision and the embedding of the 4-point plan for Transfer of Care (ToC) turnaround.

7.5 **St Helens**

Whiston hospital has been incredibly challenged following the Christmas period, leading to high numbers of ambulances being held and creating significant issues with patient flow. The Contact Cares Team continue to provide support daily and are supporting a high level of discharges. A system approach was taken

following the declaration of a critical incident, which St Helens led from a discharge point, supported by Jenny Wood. A trajectory has been agreed and a 'weekend working' pilot implemented which has performed well. The effectiveness of the system working contributed to the critical incident being stood down. A recovery group is now in place to ensure momentum is not lost.

UCR continues to experience a high number of referrals, which are being managed by the designated team supporting further admissions. Further investment into staffing has been secured for an additional 6 staff.

The Frailty in-reach team continues to attend ED, identifying those patients in ED (and ambulances) who are suitable for frailty SDEC or a virtual ward.

The St Helens Place Team is suffering staffing shortages due to sickness. There is currently no available capacity at place to support mental health flow and very little capacity to support urgent care flow. A Complex Case Mental Health Nurse is, however, working closely with our providers and continues to support patients with mental health needs with appropriate packages of care. Commissioning support for urgent care has been secured to mitigate the absence of the Head of Adult Commissioning for Urgent Care. Through joint working across Health and Social Care, we are continuing to manage the gap as staff return from sickness.

Following extensive efforts, the urgent care system was stabilised, and the Critical Incident was formally stood down on 10th January 2025. St Helens Adult Services was pivotal to the recovery of services.

7.6 **Sefton**

Specific areas of focus this period include the Better at Home programme (Q3 24/25 review) with several services and data points reviewed to measure the impact of changes.

The following high-level impacts have also been observed:

- Post Southport and Ormskirk Transfer of Care Hub (TOCH) mobilisation
- Trending reduced length of stay (LOS) and trending increased volume of discharges and morning discharges
- Increased Pathway 1 (P1) discharges from baseline – pre TOCH weekly 10.3 to 13.4 averages – this is a key objective for the programme
- Reduced Pathway 3 (P3) discharges – pre TOCH weekly 7.3 to 5.6 – this is a key objective for the programme
- Positive reduction in Medically Optimised and Fit for Transfer (MOFT) bed days lost for P3 discharges by an average 24 per week – this is a key positive indicator for the programme
- Increased P2 MOFT days lost - whilst this is a negative, the actual volume of discharges are small and should be addressed with increasing focus on P2 activity and positively impacted by the Chase Heys Test of Change,

which went live 10th December 2024 (see below for aims of the Test of Change).

- No change to volumes of Ready for Discharge (RFD).

Whilst P1 discharges have increased, the known capacity gap remains in the services particularly in the north offered by SND reablement and Mersey Care Foundation Trust (MCFT) therapy resulting in increasing use of alternative providers from 60% demand in 2023 to 80% currently.

The 'Home First' model has been agreed, with expansion plans mobilised and both providers recruiting additional staff. Additional staff plus capping LOS in reablement to maximum 21 days will see a positive impact, more people supported to go home and the delivery of a key programme objective.

Phase 1 Home First mobilisation is planned for 27th January 2025 to deliver a combined therapy and reablement model starting in the North, reducing the need to use bed base care and reducing longer term care needs as more patients are supported to go home.

P2 activity - spot purchasing of P2 activity across Health and Social care has reduced - a key objective of the programme.

NHS 'high cost' Discharge To Assess (D2A) placements are down from a high of 27 cases in June, 15 July, 11 August, and 17 September 2024.

Adult Social Care (ASC) short term beds in residential, nursing, and transitional settings have all reduced. Residential placements were in excess of 140 in January 2024 and have reduced to less than 75 in July 2024, Nursing beds from 36 in January 2024 to 16 in July 2024 and transitional beds from 58 in July 2023 to 5 in July 2024.

Underutilisation of the contracted P2 beds is evident and this has been a focus with a key of change in the Chase Heys live from 10th December 2024. The test of change brings admission decisions through the TOCH, broadens the criteria, harmonises the offer in the 28-bed base, increases skill mix between therapy and reablement and allows community therapy to move into the Home First Service. Capped LOS 14 days 28 beds from average 16 Mersey and West Lancs Trust D2A and 31 IMC. Post mobilisation the 4-week review of Test of Change at Chase Heys is showing high utilisation of the bed base with reduced LOS – 2 key objectives of the Test of Change.

Adult Social Care redesign continues and includes:

- Front door redesign and first contact processes following engagement with key stakeholders.
- Modelling of staffing requirements with resultant staffing increases - ASC have successfully recruited 3 social workers, 4 x CCA's and 2 additional Triage Officers – all posts will commence in Q1 2025.
- Handling live calls – taking out additional admin processes to expedite people getting the support they need.

We have also agreed as part of the better at Home Programme to begin the design of an integrated brokerage function to further manage our market and extend the programme scope to prevention that will include integrated care teams mobilization, a strategic review of our approach and services for dementia and delirium.

7.7 Warrington

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

- Continued improvement in the average time spent on the corridor per patient
- ED attendances remain below plan placing Warrington and Halton Hospital (WHH) in the 1st quartile (least challenged) nationally compared to the 3rd quartile (most challenged nationally) at the same point last year (based on the SAPIT dashboard information from the end of October 2024)
- Increased utilisation of the Urgent Community Response (UCR) Service in the community
- Increased utilisation of the Frailty Virtual ward moving from an average case load of 5 in April to 11 in November
- Increased utilisation of the ARI (Acute Respiratory Infection) Virtual Ward moving from an average case load of 21 in April to 28 in November
- Warrington population delay days post No Criteria to Reside running below the England average
- Achieving a left shift reduction in complex discharges addressing the Newton Diagnostic challenge of reducing over prescribing of care. April – Sept 2024 Pathway 3 discharges (into Care Homes) for the 65+ population reduced from 12% to 8% in the same period last year
- Improved 12 hour performance in the Emergency Department November 2024 compared to October 2024 and November 2023.

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

Activities and interventions that have driven these improvements include:

- engagement sessions with Primary Care, increasing referrals to UCR.
- continued focus on the Transfer of Care to minimise complex discharge delays from the point No Criteria to Reside is recorded
- increased Advance Practitioner capacity in the Frailty Assessment Unit (FAU).

Workstreams are starting to consider the next phase of actions to continue to progress and improve system performance.

7.8 Wirral

Within the Primary and Community Care Programme the GIRFT (Get It Right First Time) Team, held a 'Frail-Ted' session. The session identified opportunities

where Wirral could improve their approach to supporting those who are frail in a community setting. The outcomes of this meeting will be used to develop the outline of a crisis care project. The roll out of integrated frailty teams has now started in Wallasey, with discussions on systems, data sharing and staffing underway with a further PCN. All PCNs have now had engagement and discussions with the community trust team and are welcoming integrated working. Work on a Falls Management and Prevention strategy continues, with an expected date for presentation to the strategic group in December for approval.

There is an agreement to amalgamate the existing three separate MADE calls in Wirral, East Cheshire, and West Cheshire into a single CWP Trust wide MADE call and this is due to commence from 21st January 2025.

Rapid Improvement Events are taking place within the Mental Health programme to understand any early opportunities that could have been utilised to support people who experienced an escalation in their mental health which resulted in an inpatient admission. The themes from this work will be used to support further development of the programme. The First Response and Acute projects are now being merged to report together following a full review.

NCTR continues to remain at around 120-130 patients per day = ~13 % of bed base whilst P2 Spot Purchase Winter Contingency is available to the ToCH. CICC/HomeFirst/UCR services are all performing to contract activity requirements.

8. Primary Care Network Development

8.1 Cheshire East

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

There are few apparent significant implications from the taking of collective action to date. We have seen:

- GPs stepping back from the kind of leadership roles that they have historically occupied, and
- Some withdrawal of cooperation with shared prescribing initiatives.

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

8.2 Cheshire West

There are 9 PCNs geographically aligned to our Care Community Team and Community Partnership geographies. The only difference is that three Chester PCNs are working as one Community Partnership. This helps support alignment with Local Authority Ward Profiles

Good relationships are in place between GP practices, PCNs and the ICB with regular Practice Manager and PCN Clinical Director Forums well attended. We also hold GP Collaborative events monthly with representatives from all practices

as an opportunity to focus on areas of development, in addition to providing an update on 'Place' transformation work and recovery programmes.

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

Finally, a proposal has been drawn up by the Primary Care Team to work collaboratively with PCNs to utilise System Development Funding towards recovery priorities. Part of this proposal has now been approved, and the Primary Care Team are working collaboratively with PCNs to step-up additional on the day 'urgent' appointments in primary care. Starting in November 2024, more than 2248 additional appointments were provided during that month.

To date Cheshire West has 4 PCNs who have achieved all 3 pillars of the Capacity & Access Improvement Plan for Modern General Practice Access (this equates to 19 practices). A summary of achievement against each indicator is below:

- Better Digital Telephony: 5 PCNs (22 practices)
- Simpler Online Requests: 5 PCNs (22 practices)
- Faster Care Navigation: 4 PCNs (19 practices).

If carried out properly, the support level framework conversation is a powerful tool to engage with practices and help them to understand their strengths, weaknesses and challenges which will in turn help support them to provide the best access and care possible for their patients. The visits undertaken by the primary care team have been extremely valuable - both for the practices and the team. A wide range of excellent work has been identified as part of these conversations, and the primary care team have been sharing this good practice across the 43 practices to encourage wider adoption and resolve issues identified. Twenty-six practices have had Support Level Framework visits to date, with a further 5 visits scheduled for February 2025.

8.3 Halton

Halton Place has received confirmation of a successful bid for 2024/25 Research Capability Funding - £3624.00 has been awarded and will be utilised to develop a PCN-based Clinical Research Model in each PCN, which integrates with the Halton Clinical Research Alliance and secondary care. The model will support practices to identify and commence appropriate research studies, via an at scale approach to research and research governance.

The Integrated Neighbourhood Model - Same Day Primary Care Programme continues to progress with two key projects:

- in December 2024, the High Intensity User Pathway was expanded to provide support to patients with higher-than-expected unplanned care activity within general practice and / or the UTCs, experiencing crisis and chaotic lifestyles or at risk of becoming a High Intensity User. This aligns to the pathway already in place with A&E and referrals are discussed as part of the practice Multidisciplinary team meeting.

- funding has been made available to support both UTCs to access 'PharmOutcomes' licences. This will enable the UTCs to commence referrals into the Pharmacy First Service, building on the high number of referrals currently into this service by Halton practices, which is supporting improved access to 'on the day' care.

Both projects support the on-going development and implementation of a consistent approach to 'on the day' care across all 14 practices and the two UTCs.

The updated Halton General Practice Dashboard has been shared with all practices for an initial review. The dashboard brings together a wide range of indicators to provide a holistic view of the services and care delivered across each practice. The updated version includes an Access and Local Enhanced Services page. Practices are benchmarked by place and PCN and the aim is to utilise the dashboard to support continuous quality improvement and transformation at a practice, PCN and place level.

8.4 **Knowsley**

No significant update.

8.5 **Liverpool**

Liverpool PCN Clinical Directors/ICB meet monthly collectively across Liverpool, with PCNs continuing to attend and contribute to numerous key Liverpool system meetings - strengthening ways of working with wider system partners and stakeholders to provide more anticipatory care, particularly for people with long-term conditions and complex lives.

Our PCNs are working closely with Liverpool Place colleagues to ensure maximum and efficient usage of 2024/25 development funding. Although the 2024/25 System Development Funding/SDF was reduced across Cheshire and Merseyside ICB in November 2024, each PCN has a suite of agreed SDF plans, including the 'at scale' phlebotomy SDF plan which involves citywide / cross-PCN collaboration. Supported by their host PCNs, a high proportion of general practices have also utilised the 'Modern General Practice' funding, with plans reviewed and agreed by Liverpool Place. In addition to SDF, PCNs are now implementing various scaled up services including ADHD services and women's health hubs.

PCNs are also now contributing data regularly to the ICB's 'Enhanced Access' appointments monitoring dashboard. Data analysed over the last three quarters has highlighted that the majority of PCNs are providing more capacity above their contractual requirement.

8.6 **St Helens**

St Helens PCNs have initiated their winter plans, with additional capacity being provided over the coming weeks. The North Urgent Care Hub continues to develop and will be made sustainable long term. At the Clinical Forum on 23rd January 2025, North PCN are presenting their model and how it is funded to the other PCN CDs and Clinical Leads, with a view to whether it can be replicated across other areas as successfully. Other PCNs are also developing new ways of

working, including the trial of group consultations for long-term conditions.

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

- North PCN have their first meeting on school non-attenders in January, which has been well supported by all partners. They are focusing on primary schools.
- Newton and Haydock PCN are having their first meeting about school non-attenders in February, with a focus on high schools. They also held their meeting on complex patients in November, and although they focused on a small number of patients, each came away with an action plan to better proactively manage the care of these people.
- Central PCN has focused on developing primary care-based MDTs which are now embedded across the PCN and ready to widen membership to become a care community. Although this initially looked at a cohort of people with long term conditions, learning identified that wider partners could not play such an active role and add anything to what was already being done in primary care, and the focus has shifted to school non-attenders.
- South PCN agreed that they would take the learning from the other PCNs and start to consider their focus in 2025. A meeting is in place with the PCN Clinical Director in January to start to develop their thinking.

A procurement process is underway to secure a provider to cover clinical needs at Brookfield Intermediate Care Centre. The current level of provision is unaffordable and therefore a redesign of the primary care needs of patients within the centre has been undertaken. A procurement exercise will be undertaken to find a suitable provider who can meet these needs within the available budget.

The ICB is developing a business case to review whether the RMS booking system and GotoDoc services should continue to be commissioned, as St Helens and Warrington are the only places who have this service. This service is well embedded in St Helens and provides a significant amount of support to GP practices. It also ensures that we maximise the use of community alternatives, avoid delays by having high quality referrals, and keeping the number of Evidence Based Interventions referred to a minimum. A full impact assessment has been undertaken by the two place teams and a paper on potential options to mitigate (should the decision to decommission is agreed) has also been developed.

Financial challenges to PCNs and practices remain a risk and was discussed at length at the Place Primary Care Group. Guidance is awaited on 25/26 GP contracts and clarification on the level of uplift to mitigate any of this risk.

8.7 **Sefton**

South Sefton Primary Care Network (PCN) won ‘PCN of the Year’ for significantly improving capacity and access for patients, adding over 20,000 appointments into general practice via their South Sefton Access Service whilst also remaining responsive to local priorities, patient needs and patient voice.

8.8 **Warrington**

Warrington has 26 practices which make up our five PCNs. The PCNs and their

Clinical Directors are well embedded within the Warrington Together system and are working collaboratively with each other and with partners.

Warrington has been awarded a Research Capability Funding payment to support collaborative research working in Primary Care in 2024/2025.

In Central and West Warrington PCN, the Practice Principal Investigators (PIs) will attend meetings led by their Research Lead, Research Nurse, and Research Admin to discuss engagement and research participation.

Warrington Innovation Network will increase engagement activity within the existing PCN R&I infrastructure.

South Warrington PCN, East PCN and Central and East PCN East, will bring Practices together to discuss current individual plans with a view setting up a Primary Care research community of practice. The funding will be utilised across the existing research platforms to increase engagement with member practices.

8.9 Wirral

Work is underway to gather rationale and actions from those practices with lower patient satisfaction scores for key questions within the results of the GP Patient Survey 2024 with involvement of PCNs to provide support as appropriate due to links with PCARP.

Implementation of 2 ARI Hubs providing urgent on the day appointments, 7 days a week for all ages. These are in place for 1.12.24 until 28.2.25. Wider system working explores to support attendance prevention at WICs and ED. Utilisation of appointments is currently 97%.

9. Provider Market Development / Strategic Initiatives

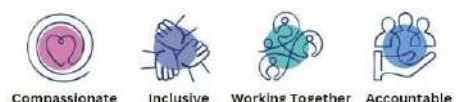
9.1 Cheshire East

Sustainable Hospital Services is the name of the programme that describes East Cheshire Trust's work principally with Stockport Foundation Trust to address some of their challenges around service sustainability.

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

The original case for change has now been refreshed. The Trust has identified a new preferred option which is being discussed with ICB Executives before Christmas.

The 'Healthier Futures' is the name of the programme that will deliver a new Leighton Hospital. The strategic outline case has been presented to the national decision-making panel. Meanwhile, work proceeds towards presenting an outline business case in Autumn 25. This is a very significant programme for us, with potentially wide-ranging implications. It is important that the hospital is 'right sized', and that any assumptions about wider place transformation are aligned to



the resources necessary to deliver them.

9.2 Cheshire West

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

9.3 Halton

Work on the Bridgewater Community Healthcare NHS Foundation Trust and Warrington and Halton Teaching Hospitals NHS Foundation Trust Integration Programme continues at pace, with regular reports provided to key stakeholders including One Halton Partnership Board and Halton Borough Council.

Senior clinical representatives from Halton Place are working with the trust to consider how best to improve healthcare for local communities which will need to encompass future ways of working, particularly as we place greater emphasis on integrated approaches and neighbourhood models of care.

One Halton partners continue to work collaboratively to explore further opportunities for strategic alignment with the Halton Health Hub at Runcorn Shopping City being one such example. January will see further progress/go live of the Runcorn Health and Education Hub in Runcorn Town Centre, secured through a £1.8m Towns' Fund grant. This project is a collaborative arrangement across health, local authority, and the local further education college.

The aim of Runcorn Health and Education Hub located in the former library is not only to improve the health and education prospects of residents, but also to encourage people back to the town centre and increase economic regeneration in the area.

The two-story split-level renovation and refurbishment of the library building will bring together a mixture of clinical and educational space, with the aim of providing specific services focused on prevention, women and children and long-term conditions. In addition, flexible facilities will support the growth of the future workforce, offering education, training, and career advice, aimed primarily at the health and care sectors. Alongside the two key functions of the building, a central multi-purpose communal space breaks down the stereotypical health hub waiting area.

9.4 Knowsley

Learning from a Merseyside Safeguarding Adult Review (MSAR) and subsequent actions involving Transforming Care & Medicines Management is as follows:

- the Host Commissioning Lead continues to receive quarterly data across all GPs (Knowsley) on % of Learning Disability (LD) Annual Health Checks (AHC) undertaken. Up to the end of November 2024, LD AHC compliance is at 50% across Knowsley and 12 Practices have completed a quality audit.
- a Medicines Management safe operating procedure has also been developed regarding the non-collection of medication for adults with LD. A monthly audit process in place to alert Practices if medication(s) is not collected, with a

follow-on audit and noting dates of LD AHC to prompt Practices of the need for regular review.

9.5 Liverpool

The Strategic Care Home Quality Group is due to ratify a number of standard operating procedures (SOPs) intended to improve quality within the market, and once approved these SOPs will be socialised across north Mersey. The Liverpool Care Homes Provider Forum is also to be reviewed and refreshed, whilst the Liverpool Medicines Management Team is rolling out plans to signpost local care homes to NHSE accredited training.

9.6 St Helens

Over the last few months, the Place Team have been working on a solution for Tier 3 Weight Management Services. This was previously commissioned by Public Health, but new national guidance has made clear that this is an NHS responsibility, therefore we have been working closely with Public Health and potential providers to find a solution, given the lack of new funding. A solution has now been identified, involving a short-term service being put in place for those at the highest risk, whilst a redesign takes place that will incorporate the introduction of any government initiatives linked to weight loss injections. The funding available linked to that is likely to be known relatively quickly.

9.7 Sefton

The Shaping Care Together Programme is now finalising its Pre-consultation business case which, once approved, is anticipated to go to public consultation in late spring / early summer. A joint Overview and Scrutiny Committee will be established between both Sefton Council and Lancashire County Council to scrutinise the proposals following Stage Two Scrutiny by NHSE and consideration by the Clinical Senate. A presentation on the progress and next stage was received at Sefton Health and Social Care Overview and Scrutiny in January.

Care Quality Commission - Adult Social Care in Sefton has had their first visit from CQC to meet the leadership team with 7 inspectors due on site from the 27th of January to the 29th of January 2025. The team will be holding sessions with groups of front-line social work staff and be meeting with key partners including chief execs of the acute trusts LUFT and MWL. There has been a request to see the CEO of the ICB as part of this process. A line of enquiry will be market leadership, quality and outcomes for Sefton residents and the approach to integration.

9.8 Warrington

A Market Position Statement engagement session is being held in January 2025 for the Local Authority and ICB to develop a joint position in relation to Prevention, Early Intervention, and the Voluntary Sector.

9.9 Wirral

Mental Palliative Care and End of Life Education Hub leads, ICB leads, and Wirral Council met to discuss the training of domiciliary care providers. The Education Hub is willing to provide training in line with the six steps for domiciliary care, but

this would require additional funding. The Wirral Council contract lead was taken to council colleagues for further discussion.

The 10 property Independent Living Pilot with Magenta Living launched in October 2024 and the first patient is now in their property as of end of November 2024. This pilot allowed us to identify properties for a patient list including both in and out of area patients in either inpatient beds or supported living placements. This will significantly reduce the cost involved with these individuals and provide greater independence / community rehabilitation.

The working group continues to progress the engagement work and modelling to redesign the current crisis step down mental health beds we have across the footprint. A paper has been through Wirral, Cheshire West, Cheshire East and CWP governance processes and an agreement to proceed has been reached. Plans around engagement and potential procurement are still being developed.

10. Children and Young People (CYP)

10.1 Cheshire East

No significant update to provide.

10.2 Cheshire West

In alignment with the development of the Cheshire & Merseyside CYP Pathway for neurodiversity, work has commenced on reviewing the early help offer and how this could be further expanded in 25/26. In addition, discussions with the Local Authority have commenced as to how a Multidisciplinary Team for Neurodiversity could be delivered across partners to provide a single point of contact for schools/SENCOs.

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

10.3 Halton

A workshop is being planned to consider the MDT arrangements that will be implemented to support children and young people that receive a neurodevelopment needs assessment profile when the "Portsmouth Model" pilot (referred to in the last Board update) commences.

The Baby Infant Bonding Service commissioned for 0–6-month-old babies has transitioned into a Building Attachments and Bonds service for 0–2-year-olds. The service was launched on 19th November 2024 and has received an increase in referrals to the service and closer working with relevant partners since the launch.

The Halton System continues to have a focus on the Special Educational Needs and Disabilities (SEND) programme and the improvements which need to be made following the last inspection outcome. The Board meets on a monthly basis and partners recently attended a stock take meeting with DFE/NHS England to understand progress and next steps. Whilst the outcome is awaited, partners continue to focus on delivery of the priority action plans.

10.4 **Knowsley**

Knowsley has developed a Children’s Joint Commissioning Plan which will support the introduction of a Section 75 for Children and Young People (CYP). Work is progressing with commissioners from both the ICB and Local Authority (LA) to understand and agree priorities for the Borough.

A Knowsley and St Helens ‘Tics and Tourettes’ pathway has been developed, with the service providing a paediatric clinic appointment to aid understanding of the diagnosis and psychological support associated with the diagnosis. The clinic offers a variety of services including psychological education, bespoke understanding of need and individual and school support where needed. Following diagnosis, parents are offered an opportunity to attend an annual online seminar, facilitated by Tourette’s Action. There is also a free training course that can be accessed by GPs.

Safeguarding Children – the Inspecting local authority services for children (ILACS) inspection has now concluded, and we are awaiting the release of the report.

Attention Deficit Hyperactivity Disorder (ADHD) current position - 970 Knowsley children and young people are awaiting assessment for ADHD as of end October 2024. 34% waiting over 65 weeks. The longest diagnostic wait is 122 weeks. The average wait to conclude assessment is 76 weeks.

Autism Spectrum Conditions (ASC) current position - 328 children and young people are awaiting assessment for ASC as of end of October 2024. The longest diagnostic wait is 115 weeks. The average wait to conclude assessment is 32 weeks.

10.5 **Liverpool**

The contract for 0-19/25 years has now been awarded, with the service being jointly provided between Alder Hey and Mersey Care. This presents an opportunity to refresh and further develop / integrate a number of pathways that will support our local families.

Our Section 75 contract arrangements have recently been subject to a partnership review and there will now be a focus on establishing more robust commissioning and QA / performance monitoring of those services that are jointly funded between the ICB/ Liverpool Place and the Local Authority. As a member of the ICB’s CYP Committee, Liverpool Place also has an opportunity to directly influence the strategic planning for C&YP services across Cheshire and Merseyside.

In terms of mental health and neurodevelopmental services (ASD and ADHD), Liverpool continues to experience an increase in demand for referrals for CYP, particularly in relation to the complexity of needs. Alder hey are also undertaking an internal transformation programme to align their ASD, ADHD and MH pathways and work is continuing locally to improve services for CYP with neurodevelopmental conditions as an integrated approach with NHS, 3rd sector and Local Authority providers supported through the C&M ND Recovery Programme, local ND and SEND JSNA.

Despite the increase in demand for referrals, there is some slight improvement in waiting times for CYP mental health services within Alder Hey (specialist CYPMH provider) and they are ahead of their trajectory for a 6 week 'waiting time to help' by March 2025. Crisis support is available 24/7, urgent support within 10-15 days and access to early help support is immediate through 'Kooth' and walk-in support at the three Young Persons Advisory Service (YPAS) hubs in Liverpool. The local offer of support across the different levels of need continues to be promoted through a series of channels, including social media (this also includes a 'whilst waiting' support offer). Local reporting has indicated an increase in access to mental health support for CYP and parents/carers.

Focused work for CYP mental health continues for the 16-25 and 0-5 age groups, Children in Care and Care leavers and Children with complex and multiple needs which supports the C&M Appropriate Places of Care (APOC) programme. Much of this focused work has resulted in additional training and resources for the workforce, CYP and families which can be accessed through the local CYPMH website (www.liverpoolcamhs.com)

With the commencement of Wave 11 Mental Health Support Teams, all primary and secondary schools will now have a mental health support offer in place as part of our local Whole Schools Approach to Mental Health and Emotional Wellbeing (MHEWB) programme.

The Enhanced Support Team, Alder Hey (national vanguard to implement trauma informed support for vulnerable CYP) in Liverpool is now integrated into the LA safeguarding teams and is continuing to demonstrate excellent outcomes for this cohort of CYP specifically in relation to fast track pathways for an Autism and ADHD assessment and diagnosis including strengthening the approach with youth justice.

10.6 St Helens

Children's A new policy document has been launched in December, 'Keeping Children Safe. Helping Families to Thrive.' This sets out a blueprint for closely working, moving towards further integration through early help and targeted care based in localities. The policy also states reforming safeguarding and early intervention approaches.

The Children's Bill, which at the time of writing was progressing through parliament, will outline changes to the delivery of some Children Social Care services as well as far greater alignment with Education, Health, and Police.

Attendance Roadshow - St Helens Local Authority Officers co-presented with the Department for Education, Ofsted, Blackburn with Darwen and Cumbria at the Attendance Roadshow at the Winter Gardens in Blackpool on 9th December 2024. This attendance-focused collaborative event allowed local authorities to showcase strong practice and offered the opportunity for colleagues to learn about different initiatives and projects aimed at improving school attendance and reducing persistent absenteeism.

Ofsted inspections- Ofsted conducted five school inspections during November and

December 2024: Hope Academy (12th & 13th November), Eccleston Lane Ends (19th & 20th November), Lyme (26th & 27th November), Wargrave (26th & 27th November) and Holy Spirit (17th & 18th December). The finalised reports, which recognise the schools' achievements, strengths and affirm the schools' already identified areas for continued improvement, will be published in Ofsted's report portal in January 2025. To aid preparation for school inspection, the local authority has facilitated training sessions for school leaders and school governors (training took place on the 12th and 26th September) focusing on changes to the inspection handbook and implementation of new national measures - both of these sessions were delivered by Senior HMIs and the agendas were co-constructed with leaders from Education and Learning.

School Effectiveness Team activity - autumn term Achievement and Improvement Board meetings have been held, with all nine secondary schools engaged with the process. Bespoke follow up sessions are planned for the spring term. Selected primary schools were invited to attend to discuss areas such as attendance, suspension rates and provisions for pupils with an identified SEND. Seven schools / provisions remain in receipt of additional support and challenge from the LA (Band B support). 12 schools will form part of cohort 1 of the Inclusive Leaders' Programme in collaboration with Carr Manor Community School, Leeds. Preparations are underway for this year's monitoring and moderation duties linked to statutory tests.

Virtual School - the Virtual School Head and Deputy Headteacher for Care Experienced Children attended a 2-day Peer Review training course in December 2024. This extensive 2-day training, provided by the National Association of Virtual School Heads (NAVSH), subsequently permits senior leaders from St Helens Virtual School to review and evaluate the practice of other Virtual Schools across the country. This will strengthen national networks amongst Virtual Schools, grant staff the forum in which to see examples of strong practice, and provide individual professional development for senior members of the Virtual School team.

Early Years - Early Years will be launching the 'Talk Pants' campaign next month. Talk Pants keeps children safe from sexual abuse and helps children understand that their body belongs to them, and they should tell a safe adult they trust if anything makes them feel upset or worried. The launch is on the 4th February 2025. Further information about the campaign can be found here:

<https://www.nspcc.org.uk/keeping-children-safe/support-for-parents/pants-underwear-rule/>

10.7 Sefton

Special Educational Needs and Disabilities (SEND) waiting times continue to see improvements in waiting times for dietetics, Speech, and Language (SaLT) and CAMHS following service improvements. Positively Dietetics and SaLT are meeting required standards ahead of the agreed trajectory. CAMHS waiting times are also in line to meet trajectory for March 2025.

Partnership for Inclusion of Neurodiversity in Schools project (PINS) pilot (March 2025) – led by NHS England is progressing providing clinical and educational specialist support to primary schools (40). Six primary schools in Sefton are signed up and receiving support from the local partnership with a bespoke offer of support based on school need including OT sensory advice and support for the

Spring Term of 2025.

The health partnership continues to drive and support the expansion of the targeted emotional health and wellbeing offer across the borough, including expansion of Team Around the School (TAS), Enhanced Support Team and Key Working Dynamic Support team. This has been further enhanced by the SEAS service for care experience young people. The partnership is also exploring funding options to develop a digital, patient-facing version of the CYP mental health snapshot.

Neuro diverse waiting times for assessment and diagnosis continue to be challenged due to the sustained increase in demand. Service improvement work continues to be progressed in conjunction with NHS Trusts and the ICB with triage and pre and post diagnostic offer of support in place whilst children and young people are waiting. The health partnership is also continuing to support the roll out of the graduated offer with partners engaging in the awareness raising and training sessions of the toolkits.

Autistic Spectrum Disorder (ASD) - Sefton and Liverpool Places have been successful in securing additional funding from the C&M ICB Transforming Care fund to expand the support for families on the ASD assessment pathway throughout the 2024/25 academic year. This includes an introductory workshop to explain in detail how the assessment process works with direct links through to the open access support offer delivered by Advanced Solutions, which families can access whilst they are waiting. The expanded offer commenced in October 2024 which will be delivered in partnership by Alder Hey and Advanced Solutions.

Sefton and Liverpool Places have also secured additional C&M ICB Transforming Care investment to support ASD assessment capacity. This will enable the Alder Hey service to deliver an additional 180 assessments across Liverpool and Sefton by the end of March 2025.

Attention Deficit Hyperactive Disorder (ADHD) - there continues to be an impact of the national shortage of ADHD medication with ongoing review by NHSE, C&M ICB and by Sefton's SEND Health Partnership. The ICB Chief Pharmacist is a member of the national medicines management group, reporting improvements of supplies by the end of January 2025.

In response to ongoing challenges for local families and significant service pressures, Alder Heys' ADHD service has reviewed its local systems and processes and will be introducing electronic prescribing systems to maximize efficiencies and enable prescriptions to be sent electronically to local pharmacies.

The service has also invested in 3 Patient Information Officers to ensure information and advice telephone lines are answered in a timely manner. Additional measures should support family/carer and patient experience.

The local health partnership is also sharing regular updates about local ADHD medication shortages and ensuring this is cascaded to SPCF, education, social care, and other partners across the Sefton system. Information is available on the ICB and Alder Hey websites:

<https://www.cheshireandmerseyside.nhs.uk/your-health/prescribing/statements/update-on-adhd-medication-shortage/>
<https://www.alderhey.nhs.uk/services/adhd/>

10.8 Warrington

The Starting Well Programme continues to deliver against the objectives set out in the Programme Plan. The programme regularly reports to the Warrington Delivery & Oversight Committee and in December presented a report to the Warrington Together Partnership Board for assurance.

In March 2023, the number of children on the CAMHS* waiting list was 190, with over 60% waiting more than 6 weeks. In October 2024, the waiting list has reduced to 40 children on the waiting list and 92% of them are being seen within 6 weeks (which is achieving the National NHSE access target).

Emergency admissions of Children and Young People (CYP) to hospital for self-harm up to March 2024 show that there are less admissions and are below average for total admissions in the previous 2 years. This is also reflected in ED activity and in length of stay for admitted CYP with mental health presentations.

NHS C&M ICB in Warrington Place have confirmed recurrent funding for the extension of all Children Community Therapy services to 19 years from April 2025. Interim arrangements for Speech & Language and Physiotherapy are in place for 2024/25.

The Warrington Place team is working with key stakeholders to manage the ongoing pressures across SEND services, in particular the Neuro-developmental Pathway. Halton and Warrington Places are working with Bridgewater Community NHS Foundation Trust and have agreed a plan to manage the existing waiting list and ensure we are working to recover the 18 week wait position over the next 12 months.

The Warrington Place Starting Well Programme Lead will be representing Cheshire and Merseyside ICB Commissioners alongside commissioners from Greater Manchester ICB at a meeting with myHappyMind and Matthew Taylor, NHS Confederation CEO and Rebecca Gray, Director, Mental Health Network. The ICB representatives will be supporting a commissioning round table including partners from Health & Education.

10.9 Wirral

The new SEND Partnership Board and its subgroups continue to meet monthly with attendance from all key stakeholders. Investment from the Local Authority supported significant recruitment into the new SEND Start Team, which includes a locality based approach and will be further strengthened through the Multi Agency Approach to EHCP decision making.

Joint funding has been agreed to enable the recruitment of two clinical coordinator posts to support with the 'health' response and contribution to plans. These posts will form part of the SEND Start functions. Further work is still required to recruit to vacant educational psychologist posts, which is impacting the timeliness and quality of statutory EHC assessments and plans.

A business case and 3-year recovery plan around ND has been developed by the two providers. The plan sets out what financial investment is required to address the growing number of children waiting for assessments and where appropriate diagnosis. The plan also explores the recruitment of a wider multi professional team, which aligns to the Cheshire & Merseyside recovery programme and national direction.

A second iteration of the Wirral Graduated Approach is in development which includes a wider sector offer, this includes the new 'Branch' Mental Health offer as well as the roll out of the Profiling Tool, ensuring a greater understanding of children's needs and appropriate and timely levels of care and intervention.

Branch launched on the 13 November 2024. The website has built in referral access to these services and currently around 35 other Wirral services supporting CYP. The matching function which provides a service or resource to CYP, parent/carers or professionals using the website has received over 150 referrals by early January 25. Wirral CYP Mental Health services provided by CWP are associate members of the contract and will provide MDT support for any referrals.

Paediatrics - development of Wirral University Teaching Hospital (WUTH) Children & Young People's (CYP) Occupational Therapy (OT) specification has continued through Q2. Work is progressing to incorporate CYP therapies service specifications including Occupational Therapy and Speech & Language Therapy services into a Section 75 agreement (joint commission between Wirral Council and Wirral Place).

Women - birthrate Plus review of maternity staffing at WUTH progressing. Maternity update given to the Core20Plus5 meeting. Service is targeting continuity of carer model in the areas where the majority of our BAME (Black, Asian, Minority Ethnic) population live on Wirral in line with national recommendations.

11. Use of Resources

11.1 Cheshire East

At the end of Month 6, Cheshire East Place reported a deficit of £36.8m, which is a £6.5m lower than the planned deficit of £30.3m.

The predicted deficit at the end of the financial year is £62.2m, which is a £10.2m adverse variance to the planned deficit of £52m. A review of potential risks and mitigations has identified a potential further net deterioration of £5.9m.

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

Cheshire East Place has delivered £2.8m worth of savings compared to the £4.7m that was included as part of the financial plan. However, it should be noted that Cheshire East Place has delivered £3.3m of non-recurrent savings in Month 7 and is currently forecasting that £12.6m of the £13.2m planned savings target will be delivered by the end of the financial year. Additional recovery plans are also being considered to mitigate the known risks and some of these have been included to date, however, there are still emerging pressures in respect of continuing healthcare and therefore these may not be fully mitigated.

11.2 **Cheshire West**

At the end of Month 8, Cheshire West Place reported a deficit of £32.6m, which is £4.1m over the planned deficit of £28.4m.

The predicted deficit at the end of the financial year is £50.6m, which represents an £8.0m adverse variance to the planned deficit of £42.6m. A review of potential risks and mitigations has identified a potential further net deterioration of £2.2m, and therefore the risk adjusted forecast outturn is a projected deficit of £52.8m which is a £10.2m adverse variance to plan.

Cheshire West place has delivered £2.9m worth of savings compared to the £5.2m that was included as part of the financial plan. However, it should be noted that Cheshire Wests Place is indicating that £5.4m savings target will be delivered by the end of the financial year. Additional recovery plans are also being developed to mitigate the known risks but there remains a risk that these may not be fully mitigated.

11.3 **Halton**

At the end of Month 8, Halton's reported position was a year-to-date deficit of £8.5m (against a plan deficit of £6.2m for the same period), with the full-year outturn forecast remaining (as previously reported for Month 6) at a £12.8m deficit against the annual Plan deficit of £9.4m). The main drivers of the adverse full-year outturn position continue to be projected budget overspends in relation to:

- All Age Continuing Healthcare - particularly in respect of adult fully funded and fast-track packages (together forecasted to exceed budget by £2.0m) due to complexity and growth pressures
- Mental Health packages of care – specifically in respect of Mental Health Act placements (£1.3m forecast overspend) and complex Learning Disability packages (forecast to outturn at £0.6m over-budget)
- Prescribing – with cost pressures and QIPP shortfall being the principal contributors of the projected £1.0m overspend.

In addition, Halton Place has identified further net risks with a total expected value of £0.7m; the main components of this are: potential further demand/acuity-led growth risk in respect of Mental Health (£0.2m) and Continuing Care (£0.6m) packages; additional Prescribing cost efficiency delivery shortfall (£0.4m) and estimated costs relating to the transfer of responsibility for Learning Disability Nursing services and Tier 3 Specialist Weight Management Service (from Halton Borough Council).

Principal mitigations to date remain the expected Section 75 Pooled Budget

underspend (estimated at £0.3m) and projected savings from the Prescribing Waste Mitigation initiative (£0.2m); however, these exclude potential benefits arising in relation to Transforming Care underspends and Weight Management drug funding. The scope for identifying further cost-saving opportunities likely to have a favourable in-year impact on the risk adjusted variance from Plan (i.e., £4.1m adverse) is recognised to be significantly diminished in the latter half of the financial year.

In addition, the imperative to prioritise investment to deliver the Halton SEND Improvement Action Plan arising from the previous CQC review has further restricted the potential for further recovery within 2024/25. In light of this, the focus of the Place team for the remainder of the financial year will be containing the outturn position currently forecast against further demand/acuity cost pressures, including through robust validation/challenge of invoices received and close working with Halton Borough Council in respect of joint and aligned budgets.

11.4 **Knowsley**

At the end of Month 8, Knowsley Place reported a surplus of £7.0m, which is a £0.9m adverse position to the planned surplus of £7.9m for the period to date.

The predicted surplus at the end of the financial year is £9.8m, which is £2.1m below the planned surplus of £11.9m. A review of potential risks and mitigations has identified a potential further net improvement of £0.9m to that position, and therefore the risk adjusted surplus is projected to be £10.7m. The Financial Recovery target, to deliver the financial plan, is a further £1.2m and mitigations continue to be developed to deliver against this.

Knowsley Place has delivered £2.1m worth of savings in line with the planned levels to date and projections are that the full efficiency plan of £3.4m will be delivered by the end of the financial year.

11.5 **Liverpool**

At the end of Month 8, Liverpool Place deficit was £2.4m which is £9.5m above the planned surplus of £7.1m and reflects an adverse position.

The predicted deficit at the end of the financial year is £6.2m which is £16.8m above the planned surplus of £10.6m. A review of potential risks has identified additional risks of £3.3m. Additional mitigations reduces this to a risk adjusted deficit of £16.6m.

Liverpool Place has delivered £5.2m worth of savings compared to a plan of £7.6m. Liverpool Place is indicating that the full efficiency plan of £11.9m will be delivered by the end of the financial year.

11.6 **St Helens**

Estates continues to present various risks, with lease negotiations ongoing across various primary care buildings. Negotiations can be slow due to demands of both parties, but are being supported by the Central Estates Team, who have the expertise to support these complex issues. However, whilst leases are not in place, the risk of landlord eviction remains and therefore discussions remain ongoing to avoid that scenario.

We have secured a significant amount of money through Section 106, where housing developers pay towards improved infrastructure costs in primary care as part of new developments. Further monies are expected as developments go through the planning process. We are working with the affected practices on how they can use the funding to support enhanced infrastructure for their practice.

At the end of Month 8, St Helens Place reported deficit was £9.7m, which is a £2.3m adverse position to the planned deficit of £7.4m.

The predicted deficit at the end of the financial year is £14.3m, which is £3.2m adverse to the planned deficit of £11.1m. This is an improvement on the position reported at month 6 by £0.2m. However, a review of potential risks and mitigations has identified a potential further net deterioration of £1.7m to that position – primarily related to the GP prescribing budget and increasing CHC costs, and therefore the risk adjusted deficit is projected to be £16.0m.

For the 5% planned cost reductions, St Helens Place has delivered £2.7m worth of savings compared to a plan of £3.3m, which is an adverse variance of £0.6m. This adverse position is mainly related to AACC savings plans due to staff shortages and IT system transition, but it is anticipated that this position will improve as the year progresses. The St Helens team are continuing to try and identify further cost reduction opportunities as part of the financial recovery and hope to report an improved position as the year progresses.

11.7 **Sefton**

At the end of Month 8, the Sefton Place financial position was a deficit of £15.3m which is £8m above the planned deficit and reflects an adverse position.

The predicted deficit at the end of the financial year is £25.8m, which is £15.3m above the planned deficit of £10.5m. A recovery plan which identifies cost reductions of £12m has been agreed and implemented and there is further work required to address the remaining savings required. £3.2m recovery savings have been achieved to date but cost pressures also continue to increase, which impacts upon the overall financial recovery.

The overall financial position is significantly overspent compared to plan and remaining recovery savings identified will not reduce expenditure sufficiently to deliver the agreed financial plan. Sefton Place have a significant challenge to reduce costs further for the remainder of the financial year.

In respect of the agreed efficiency target included in the financial plan for 2024/25, Sefton Place has reported £4.4m worth of savings within the Month 8 position and is on target to achieve the full efficiency plan of £7.795m by the end of the financial year.

11.8 **Warrington**

At the end of Month 8, Warrington Place's reported deficit was £4.3m, which is £1.2m adverse to the planned deficit of £3.1m.

The predicted deficit at the end of the financial year is £6.4m, which is £1.8m above the planned deficit of £4.6m. A review of potential risks and mitigations has identified a potential further net risk of £0.1m, therefore the risk adjusted deficit is projected to be at £6.5m.

Warrington Place has delivered £3.2m worth of efficiency savings year to date, compared to a plan of £3.0m (i.e., £0.2m favourable). With anticipated annual savings of £5.2m against a plan of £4.5m (i.e., £0.7m favourable).

11.9 **Wirral**

The Wirral Medicines Management Team has made significant progress in developing a more cohesive and detailed recovery plan which is directing their workplan and making best use of resource and capacity within the team. This has increased confidence in the plans being put forward and in achievement of proposed targets.

Pharmacy access – in November 2024 we were advised that Allied Pharmacy (APH site) intended to reduce their supplementary opening hours from 2nd December 2024. This created a gap after 4pm on a Sunday, especially for patients attending our Miriam Walk in Centre as they held no stock of pre-labelled medicines that they could supply if needed. Initial mitigations were put in place to ensure that any patients with an immediate need for medication after 4pm could be supported via a taxi, but with a longer-term solution of ensuring Miriam WIC had their own stock of medicines that could be supplied if needed. This stock is now in place and assurance has been received regarding the governance within the service to manage this. Work will now continue with the pharmacy contracts team to explore how this access gap can be filled as there are implications for other community services and our OOH provider.

12 **Officer contact details for more information**

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Meeting of the Board of NHS Cheshire and Merseyside 30 January 2025

Highlight report of the Chair of the ICB Remuneration Committee

Agenda Item No: ICB/01/25/12

Committee Chair: Tony Foy,
ICB Non-Executive Member



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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	27 November 2024

Key escalation and discussion points from the Committee meeting

Alert

n/a

Advise

The Remuneration Committee at its meeting on 27 November 2024:

- received a report on a proposed appointment process for the ICB Chief Executive position. The Committee approved the proposed salary range for the Chief Executive position and agreed the establishment and composition of the Appointments Panel to oversee and support the Chair in the appointments process.

Assure

n/a

Meeting of the Board of NHS Cheshire and Merseyside

30 January 2025

Highlight report of the Chair of the ICB Audit Committee

Agenda Item No: ICB/01/25/13

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



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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	03 December 2024

Key escalation and discussion points from the Committee meeting

Alert

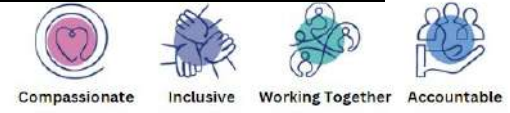
The Audit Committee at its 03 December 2024 meeting:

- approved the ICBs Section 75 Operational Policy, which provides clarity and guidance to all places across the ICB for renewal, amendment or expansion of s75 agreements, thus helping to ensure consistency in documentation, approval and governance across all places. It was also agreed that the ICB should develop a similar policy for Section 65z5 and Section 65z6 arrangements.
- approved minor amendments to the ICBs Managing Conflicts of Interest Policy and the ICBs Working with the Pharmaceutical Industry Policy
- approved changes to the ICBs Information Governance, Data Security and Protection Polices, including the stand down of the Consent Policy and the Subject Access Request Policy.

Advise

The Audit Committee at its 03 December 2024 meeting:

- received an update report on Procurement waivers approved in line with the ICBs SORD between 01 June to 30 November 2024, and an update on the retrospective waivers outstanding from 2023-24. The report outlined that there had been a breakdown in the process of approving and reporting of waivers which had resulted in the need for retrospective approval, however the decision to commit expenditure had been conducted in line with the SORD and approved at appropriate committees at Place. The Committee were informed that the ICBs procurement team were working with Place teams to ensure the processes would be tightened to address and prevent future errors. The Committee noted the report.
- received an annual assurance report from the ICBs Freedom to Speak Up (FTSU) Guardian which provided the Committee with the current position in relation to Freedom to Speak Up (FTSU) arrangements for the ICB and which outlined the plans to develop FTSU arrangements, as well as key achievements. Committee requested that the ICB FTSU policy and Committee TOR were reviewed to ensure that there was alignment and clarity regarding the role of the Committee in relation to FTSU and that of other forums such as the ICBs People Committee and the Board. The Committee noted the report.
- received the ICBs Quarter Two Freedom of Information (FOI) report outlining the number and type of requests that the ICB had received from 01 August to the end of October 2024. The Committee were informed that the ICB had received 122 FOIs during this period, that the ICB was 100% compliant in responding to FOIs within the statutory timescale and that the main themes with respect to FOIs centred around Continuing Healthcare/packages of Care, weight management services, women’s health hubs and NHS Dental contracting. The Committee noted the report.



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<ul style="list-style-type: none"> • received a report providing an update on the ICBs controls and processes around managing declarations of interest. The Committee received details on the declarations made around gifts, hospitality and sponsorship and received assurance on the process undertaken to approve those that fell technically outside of the ICBs policy. The Committee noted the report. • received the Quarter Two Subject Access Request (SAR) Service Update report. Committee members were informed that the ICB had received 28 new SARs during this period, with 15 closed on time, 5 closed outside of timescales and 8 in progress. The Committee noted the report. • received the Quarter Two Information Governance Service update report highlighting key changes to the Information Governance, Data Security and Protection Polices, including the stand down of the Consent Policy and the Subject Access Request Policy, and received updates on progress to date against the delivery of the IG service. • received a report on the ICBs Risk Management processes providing assurance on the effectiveness of the ICBs internal processes and the role of the Committee in delivering its responsibilities in relation to risk and as outlined within the Committee Terms of Reference. The Committee noted the report. • received a report from the ICBs Internal Auditors outlining progress against the Annual workplan for 2024-25. The Committee noted the progress report. • received and noted the progress report from the ICBs Anti-Fraud specialist in accordance with the ICBs agreed anti-fraud workplan. • received and noted and update paper from the ICBs External Auditors which outlined emerging national issues and developments that may impact ICBs, NHS sector updates and progress against the 2024/25 deliverables. The Committee noted the update report. • received the Committees risk register, reviewed the 5 risks assigned to the Committee. Further discussion was had regarding cyber risks and the recent cyber incidents that occurred in Cheshire and Merseyside. Committee noted that the Board was due to have a cyber update at its meeting in January 2025 and this should inform further the risks associated with cyber security. The Committee noted the report.
<p>Assure</p>
<p>n/a</p>

The next meeting of the Committee is scheduled for 04 March 2025

Meeting of the Board of NHS Cheshire and Merseyside

30 January 2025

Highlight report of the Chair of the System Primary Care Committee

Agenda Item No: ICB/01/25/14

Committee Chair: Erica Morriss
ICB Non-Executive Member



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Highlight report of the Chair of the 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	December 2024.

Key escalation and discussion points from the Committee meeting

Alert

1. General Practice – current workload pressure on practice teams and difficulty in time management around completion of mandatory training.
2. Community Pharmacy - Challenge of outstanding contract and actions that could be taken through collective action.
3. Optometry - Challenge with contract and impact on supporting rural locations. Positive direction for inclusion in ICB Strategic Digital and Shared Care Records agenda
4. Dentistry - Workforce pressure (existing and new) and difficulty of management of clinical networks.
5. Primary Care Finance - Prescribing 26.4m overspend even-though significant positive interventions in place.

Advise

Dental Mid-Year Review

Provided the background to the NHS Primary Care Dental Contract Mid- Year Review process and assurance that the work required has been completed. Updated the Committee on the current Mid-Year position for 2024/25 across Cheshire & Merseyside and actions being taken forward. Feb 25 SPCC will be assured of progress regarding Strategic Dental Access across 6 pathways.

Primary Care Estates Update

The Committee welcomed this initial detailed report which highlighted areas of key risks In summary the committee stated they were very supportive and thanked the team for the good work and confirmed that PC Estates would now be a bi-monthly standard agenda item to ensure sufficient time given to probe and gain assurance of PC Strategy.

Contracting, Commissioning & Policy Update

Information and assurance in respect of key national policy and related local actions in respect of;

- GMS/PMS
- General Ophthalmic Services (GOS)
- Community Pharmacy
- Primary Care Dental Services.

Noted and were assured of actions to support any issues raised in respect of Cheshire and Merseyside contractors.

Quality Update

Noted QSAG progress with 9month consolidated position to be presented to SPCC in Feb 25.

FTSU

Regular item for SPCC to drive understanding of the support across the 4 contractor groups and an opportunity for the ICB to share best practice.

Digital Update

System Primary Care Committee noted update on current Primary Care Digital programmes workstreams across all nine places within Cheshire and Merseyside ICB This includes national and regional commitments, detailing the mandated and local priorities for 2024/25 with associated risks and issues.

Detailed planning is now underway for delivery of key milestones in the Digital Primary Care sub strategy, progress will be reported to this Committee on an ongoing basis.

Work is continuing at pace on the Blinx pilot along with establishing appropriate governance and a robust independent evaluation process which will be led by the Health Innovation network.

Access Improvement Plan Update

Assurance provided to SPCC on progress of the ICB's Access Improvement Plan at both system and place level. The Committee was asked to discuss and note including the Board feedback. Healthwatch to present client experience on GP access following resident consultation - Feb SPCC.

Assure

Committee risk management

Meeting undertaken outside of SPCC with aims

1 – Ensure all risks are aligned to achievement of Primary Care Strategic priorities – PC Strategic Plan, PCARP, Dental Access.

2 - Review all Risks currently delegated to SPCC, a paper to come back to Feb SPCC to detail risk accountability of SPCC sub-committees and proposed governance arrangements - Primary Care Workforce, PC Estates & PC Quality.



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Meeting of the Board of NHS Cheshire and Merseyside

30 January 2025

Highlight report of the Chair of the Women's Hospital Services in Liverpool Committee

Agenda Item No: ICB/01/25/15

Committee Chair: Prof. Hilary Garratt
ICB Non-Executive Member



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Highlight report of the Chair of the Women’s Hospital Services in Liverpool Committee

Committee Chair	Prof. Hilary Garratt
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	27.11.2024

Key escalation and discussion points from the Committee meeting

Alert

The Committee considered the following at its meeting in November 2024:

Terms of Reference

The Terms of Reference (ToR) for both the Committee and the Programme Board have had their annual review. Both have had minor changes made to reflect changes in membership.

The Committee approved the updated Terms of Reference for the Programme Board and agreed the updated Terms of Reference for the Committee.

The Committee recommends that that the ICB Board approves the updated Women’s Hospital Services in liverpool Committee Terms of Reference (Appendix One).

Advise

The Committee considered the following at its meeting in November 2024:

Phase 2 Programme Plan

The next stage summary programme plan – from January – December 2025 - was presented to the Committee. The plan set out the timescales and milestones for agreeing the model of care, managing the options appraisal process and developing any business cases. A diverse range of clinicians and the Lived Experience Panel will be involved in all aspects of the work.

The Committee approved the phase 2 programme plan.

Lay Representation on the Committee

It was proposed that members of the Lived Experience Panel (LEP) could attend future Committee meetings on a rotational basis, to provide a lay perspective, rather than recruiting public advisers separately.

The Committee agreed to LEP members joining the Committee, instead of recruiting public advisers, and the Terms of Reference have been updated according.

Assure

The Committee considered the following at its meeting in November 2024:

Programme Update

The Chair of the Programme Board provided an update on programme activity since the September meeting. This included:

- Finalising the case for change and briefing councils and MPs prior to publication.
- Planning and delivering the public engagement for the case for change.
- Progress on delivering clinical improvements at LWFT.
- Refreshing the counterfactual case.
- Planning for the clinical engagement event in December.

The Committee noted the programme update and progress made since the last meeting.

Communications and Engagement Update

The Committee received feedback on the 6 week public engagement period which completed the day before the meeting.

The engagement process and products included face-to-face and online engagement events, a dedicated website, and a public facing version of the case for change (including an easy read version). Voluntary sector organisations were also commissioned to support the engagement with harder to reach groups and communities.

Feedback on the case for change was collected via a questionnaire (on line and printed and available in an easy read format). This was also translated into 16 languages. An independent organisation, Hood and Woolf, has been commissioned to complete the analysis of the questionnaires; the Committee will receive the report of the analysis at its next meeting.

The engagement events proved to be challenging with some individuals dominating the sessions. More resources are likely to be needed for effective engagement activities in the future, to ensure all attendees can have a voice.

The Committee noted the verbal report about the public engagement and the need for greater resources for future events.

Risks Review

The Committee received the current risk register, with updated actions, progress reports and scores. Only risk scores for communications and engagement have been reduced.

There will be a full review of the risks following agreement of the phase 2 programme plan.

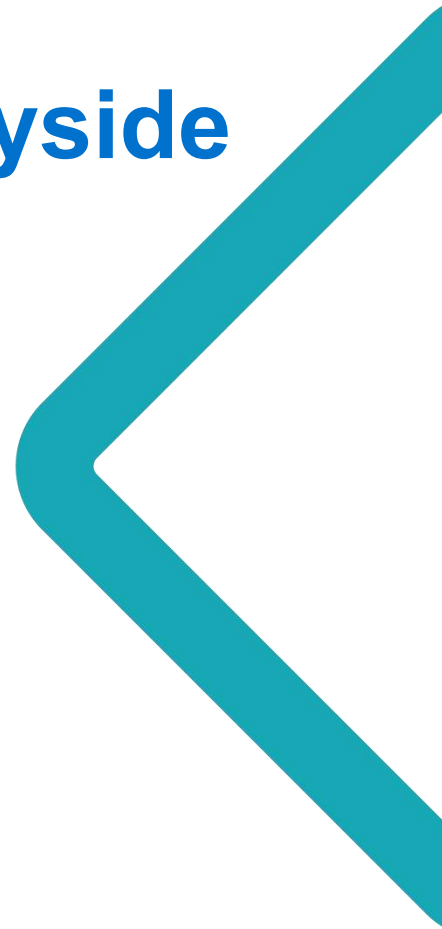
The Committee approved the current programme risks and risk scores.

Date of next meeting: 19 March 2025

NHS Cheshire & Merseyside Integrated Care Board

Women's Hospital Services In Liverpool Committee

Terms of Reference v2.3



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
30.10.24	2.3	Updates to membership and attendees section to reflect current membership		Clare Powell

Review due:
November 2025

Women's Hospital Services in Liverpool Committee

Terms of Reference

1. Purpose

The Women's¹ 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 2023,² 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.

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 <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:
 - Considering, endorsing and recommending the strategic case for change to the Board of the ICB for its approval
 - agreeing the programme governance arrangements, that ensures robust development of options and evidence of how conclusions have been reached.
 - establishing a women's hospital services in Liverpool (WHSIL) 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. This will include:
 - developing and maintaining processes to ensure that there is meaningful involvement of the public, patients, carers, and stakeholders in the development of proposals.
 - ensure that any relevant Health Overview and Scrutiny Committees (HOSC) 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 Board of the ICB, and keeping the Board of the ICB apprised of progress and identify significant risks to the delivery of the programme work plan.

3. Authority

The Committee will oversee the development of proposals for 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 WHSIL 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 ICB Board membership; 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 - a Non-Executive Member of NHS Cheshire and Merseyside
- 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 Director
- the ICB Associate Medical Director (Transformation)
- the ICB Director of Finance
- an ICB Primary (GP) Care Partner Member representative (Deputy Chair)

- a representative from the Cheshire and Merseyside Local Maternity and Neonatal System
- the ICB Liverpool Place Director
- the ICB Sefton Place Director
- the ICB Knowsley Place Director
- a clinical representative from CMAST
- up to 2 members of the Lived Experience Panel
- 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 WHSIL 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:

- 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
- Members of the Programme team including the Programme Director and the chairs of working groups.

The programme director and any other dedicated staff will support the operation of both the Committee and the WHSIL 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 who will act as the representative 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 Liverpool 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 a Non-Executive Member of NHS Cheshire and Merseyside .

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 Director 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 as the programme plan dictates which is expected to be 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 may be 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 its 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 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 Merseyside for approval.

Meeting of the Board of NHS Cheshire and Merseyside 30 January 2025

Highlight report of the Chair of the Strategy & Transformation Committee

Agenda Item No: ICB/01/25/16

Committee Chair: Dr Ruth Hussey
ICB Non-Executive Member

Highlight report of the Chair of the Strategy and Transformation Committee

Committee Chair	Dr Ruth Hussey
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Meeting date(s)	16 January 2025

Key escalation and discussion points from the Committee meeting

Alert

At its meeting in January 2025 the:

- Committee endorsed the Vulnerable Services Policy for inclusion in 2025/26 contracts. The policy is a response to instances where services have been either restricted or closed without formal process that has impacted upon neighbouring Trusts. Committee noted the policy aims to strengthen governance around decisions to make service changes when a service is vulnerable and to ensure it is managed in the best interests of patients and all partners within the system. Committee endorsed the policy but suggested involvement of trust CEO/Executive Board as part of the sign off to close provision and that quality impact assessments are overseen and approved by the relevant Director of Nursing. The committee requested that the Clinical Effectiveness Group take strategic oversight of patterns and trends to inform planning.
- future of the Strategy & Transformation Committee was discussed following the completion of the MIAA work into Board and committees, with one of the proposals to stand the committee down with a move to reporting assurance through to Board being undertaken in a different way. Committee agreed that there is a need to ensure everyone is working together across the various groups and forums and that the Executive is requested to find a cross system way of working to ensure that what is reported to Board is strongly assured and driven by partnership working.

Advise

At its meeting in January 2025 the:

- Committee received an update on the delegation of specialised commissioning in 2024/25 including shared transformation priorities, key performance challenges within delegated services and an overview of services to be delegated in 2025/26. Committee was informed of the priority shared workstreams, which include CORE Kidney Project, Optimising Stroke Pathways – From 999 to Thrombectomy and Neurorehabilitation – Care Model & Integrated Case Management. These workstreams were agreed between NHS Cheshire & Merseyside and NHS England Specialised Commissioning with progress on these being presented at the meeting. Committee heard key challenges within delegated services and mitigating actions to these were outlined to provide some assurance. Committee agreed that specialised commissioning should be integrated with broader commissioning at the ICB level. It was important to look at commissioning and quality across the pathway to understand the impact on our population including inequality of access and outcomes. Committee recommended the C&M

Specialised Commissioning Oversight Group (SCOG) to look at the potential risks that will be inherited from April to advise Board.

Assure

At its meeting in January 2025 the:

- Committee received a paper providing an update on the ICB's Transformation Programmes for Q3. The paper highlighted key achievements, key risks and issues. At the last meeting, Committee requested governance reports for the portfolio of programmes that report into it. Committee noted the report but recognised the need to define the level of detail needed to provide assurance for Board going forwards, including Population Health and Clinical programmes. Committee also recognised the need to link in with the strategic objectives Board wants to achieve next year, providing the measurable outcomes and milestones to them as part of a coherent framework.
- Committee received a paper outlining the work underway to design work programmes in support of developing community services across Cheshire and Merseyside. Committee was informed that there will be two documents published alongside the 2025-26 NHS Planning Guidance in January 2025. These being the Community Health Services Universal Offer (describing the core components to be delivered universally within community health) and Neighbourhood Health (Identifying good practice in implementing Integrated Neighbourhood Models). The draft Neighbourhood Health Guidelines was presented and noted by Committee. Committee was updated on the work that is progressing, including working with the Provider Collaboratives and wider partners to scope a programme focussed on the universal offer and also the work on establishing a baseline understanding of the status of Integrated Neighbourhood Health implementation across the nine Places.
- Committee received an update on the progress on Commissioning Intentions for 2025/26, outlining the review of plans by programmes and a review of these against the prioritisation framework to validate and prioritise them, as well as consideration of the National Planning Guidance and financial allocations for further development and refinement of priorities and agreeing with Board the key strategic priorities.
- Committee was presented with the regular risk report. The report detailed the three principal risks, and four corporate risks escalated in accordance with the Risk Management Strategy. Committee noted that there have been no changes to the risk scores since the previous meeting in November 2024. Committee was also briefed on the two recent cyber incidents which impacted a number of sites across Cheshire and Merseyside and the actions taken following these as well as mitigations to the risks.

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
14DR - There is a risk of the ICB's critical information systems suffering a failure due to a cyber security attack leading to possible financial / Data loss, disruption to services and patient care and/or damage to the reputation of the organisation	Committee noted that there has been no change to this risk following the last meeting on 21 st November 2024.meeting
T1 - Unable to achieve NHS directives on emissions as mandated and targeted in the Green Plan which will impact on the ICB's reputation and opportunity to deliver financial savings	Committee noted that there has been no change to this risk following the last meeting on 21 st November 2024.
T2 - Impact on health outcomes and inequalities through limited Access to Specialist Weight Management Services across Cheshire and Merseyside and litigation in non-compliance with NICE Technology Appraisals in relation to GLP1 Weight Loss Drugs	Committee noted that there has been no change to this risk following the last meeting on 21 st November 2024.
T3 – Health Inequalities funding	Committee noted that there has been no change to this risk following the last meeting on 21 st November 2024.
T4 - SDF funding	Committee noted that there has been no change to this risk following the last meeting on 21 st November 2024.

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.	Committee noted that there has been no change to this risk following the last meeting on 21 st November 2024.

Board Assurance Framework Risks	
<p>P8 - The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services</p>	<p>Committee noted that there has been no change to this risk following the last meeting on 21st November 2024.</p>
<p>P11 - The ICB is unable to address inadequacies in the digital infrastructure and related resources leading to disruption of key clinical systems and the delivery of high quality, safe and effective health and care services across Cheshire and Merseyside</p>	<p>Committee noted that there has been no change to this risk following the last meeting on 21st November 2024.</p>

Meeting of the Board of NHS Cheshire and Merseyside

Highlight report of the Chair of the Cheshire and Merseyside Health and Care Partnership

Agenda Item No: ICB/01/25/17

Committee Chair: Cllr Louise Gittins
Leader of Cheshire West and Chester Council



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Highlight report of the Chair of the Cheshire and Merseyside Health and Care Partnership

Committee Chair	Cllr Louise Gittins
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	10 December 2024

Key escalation and discussion points from the Committee meeting

Advise

PCC update-Cheshire and Merseyside

The Police and Crime Commissioners for Cheshire and Merseyside presented slides in relation to serious violence prevention. It was recognised by members that a partnership approach was required to address serious violence via a public health approach, including undertaking early prevention work with identified vulnerable individuals at risk of criminality.

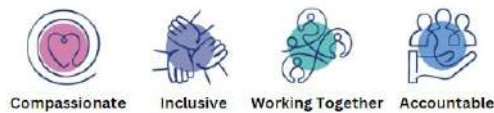
Members heard about a number of key issues and initiatives which included:

- funding had been utilised to undertake a successful serial perpetrator programme and a national charity called Street Games had worked with young people identified as being at risk of criminality and anti-social behaviour. There were additional organisations within Cheshire who provided mentoring to young people which involved meeting with Directors of Childrens Services and schools to promote their service and encourage referrals. It was noted that there was evidence that funding these early preventative initiatives had saved public money. An investment in software had also been made to develop data sharing with Local Authority and Community Safety Partnerships colleagues.
- Members were advised that it was important that there was partnership working in terms of risk sharing and investment to address serious violence and criminality within the community. It was reported that in July the HCP had agreed to provide funding for prevention.
- It was felt that there needed to be a greater emphasis on learning disability and poor mental health as a vulnerable cohort of people at risk of criminality, in addition to neurodiversity. The opportunity was offered to broker discussions between the Police and colleagues from Merseycare to identify what could be achieved collaboratively, particularly in supporting officers in managing people with neurodiversity to prevent escalation.
- It was queried whether there was more that could be done in relation to data sharing.
- Members advised that there was a lot of community work being undertaken by the voluntary and faith sector and that it would be worthwhile to have further discussions with them to combine their efforts. It was acknowledged that it would be beneficial to increase the number of community youth clubs and positive role models for young people within the community.

Housing and Health Partnership Launch

A set of slides were presented which outlined the Cheshire and Merseyside Health and Housing Partnership priorities, partnership, ambitions and focus on delivering on All Together Fairer.

It was noted that there were opportunities for all partners to contribute and that further understanding was required as to how this could be achieved.



The discussion included a number of key points and issues:

- Members felt that it was important that the plan added value and did not duplicate what was already taking place as there was lots of positive work being undertaken within local authorities to address health and housing priorities. The Health and Care Partnership workshop in 2023 had recognised that there was insufficient specialist accommodation for residents with more complex needs and that the ICB were working in collaboration with partners to address this, including colleagues from Torus.
- It was noted that there was a lot of good work being undertaken in Cheshire and Merseyside to support patients, carers and families in preventing homelessness.
- Members were advised that the Liverpool City Region were undertaking a housing report which she agreed to circulate once finalised. The report recognised the role of the voluntary sector in supporting the agenda, particularly in relation to workforce development for tenants and care navigation intervention.
- It was accepted that there were lots of challenges for Cheshire and Merseyside and members were asked to be champions through their own networks of this important work

Green Plan and Sustainability update

Committee members were referred to the Green Plan and sustainability update contained within the meeting pack and were asked for their comments prior to it being endorsed by the Board in January 2025.

Members were advised that the ICB had a statutory responsibility from NHSE to have a Green Plan, which was widely representative of all Providers and Places across Cheshire and Merseyside. Individual providers also had their own green plans and there were sustainability leads working across Cheshire and Merseyside who were enthusiastic about the planet and wanted to make a difference.

It was discussed that as one of the major employers in the country, the NHS had the opportunity set targets as to how they could contribute to existing measures being undertaken to prevent climate change. The four key areas of discussion were noted:

- Extreme Weather Events – the sustainability team were engaging with regional colleagues to develop a framework.
- Air Quality – the sustainability team were working to develop an air quality framework. Wirral had a Burn Better Campaign to address concerns in relation to wood burning stoves.
- Local Nature Recovery Strategies – work had been undertaken to map out existing sites within the hospital trusts to boost nature recovery and lots of work had been ongoing via the Mersey Forest. There was also reference made to green spaces within social prescribing for GPs.
- Procurement – there are lots of examples of good practice in relation to the reduction of noxious gasses to reusable clothing.

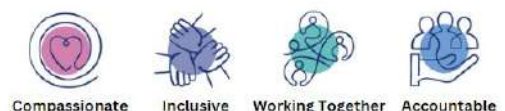
Members were asked to endorse the Green Plan and to commit their own organisations to help to meet the actions and targets set. It was recommended that an update be provided by the sustainability team in 12 months.

Assure

n/a

Date of next meeting:

18 February 2025



Meeting of the Board of NHS Cheshire and Merseyside

30 January 2025

Freedom to Speak Up (FTSU) Update

Agenda Item No: ICB/01/25/19

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



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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 2026, to use the FTSU Self-Assessment tool to help the Board reflect on its position and the improvement that has been made since first completion in January 2024 and what is needed to meet the expectations of NHSE and the NGO. This report provides an overview of the good progress made with the FTSU arrangements within the ICB and areas of development.

2. Executive Summary

- 2.1 NHS England has outlined its 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). In October 2024, NHSE asked ICBs to ensure that FTSU arrangements are in place for system partners in primary care by 2026. Work is underway with C&M ICB primary care to provide assurance to NHS England that their staff know how to reach a FTSU guardian who is trained, registered with the National Guardian's Office, and named in their local FTSU policy. This will support workers with speaking up where needed.
- 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 completed in January 2024, to help develop its FTSU arrangements (**Appendix One**). The initial assessment overall showed a low baseline for 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. This continuous improvement is evidenced in the difference between the FTSU Action plan January 2024 (**Appendix Two**) and FTSU Action plan December 2024 (**Appendix Three**) as the FTSU arrangements have continued to develop since the recruitment to the FTSU Guardian post in April 2024. A second self-assessment and reflection tool is due to be completed in January 2026 to show the ICB improved 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 current FTSU Action Plan is included at **Appendix Three**.
- 2.7 The current reporting for 2024/25 is 29, having previously being nil, the number of FTSU cases reported has increased steadily since the recruitment of the FTSU Guardian lead who has continued to raise the profile of FTSU across the ICB.

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 (5.11)
 - **endorse** the updated action plan (**Appendix Three**) to further develop the position in relation to FTSU.

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. Line managers fully engaged in making FTSU business as usual. It is acknowledged that awareness about speaking up within the ICB is increasing, however there is still much work to be done in building trust and confidence in the FTSU process.
- 5.4 We want to develop a culture where 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 and will continue to use 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 recruitment to a dedicated Guardian. The FTSUG lead engaged with senior leaders at the senior leadership forum in September 2024, to raise awareness on speaking up and FTSU profile.
- 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 with completion rate of 90%.
 - development of the FTSU strategy.
 - 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.
 - the recruitment of a dedicated FTSU Guardian, Temitayo Roberts.
 - increased promotion of FTSU and the role of Guardians including through staff communications, the staff hub, 'we are one' session, face to face staff events and the ICB organisational induction programme.
 - celebration of FTSU speak up month in October 24 and the theme of power of active listening.
 - establishment of the FTSU summit, a forum to review FTSU data and triangulate with other business intelligence from across the organisation.
 - development of the FTSU page to improve navigation access to speak up

resources.

- update of the FTSU (whistleblowing) policy to align with the NHS standard FTSU policy template according to the NGO and NHS England’s guidance.
- increased promotion of FTSU and the role of Guardians and Ambassadors through staff communications, posters, the staff hub, ‘we are one’ session and face to face staff events, across all 9 places, corporate teams and directorates.
- FTSU Guardian lead’s attendance at Primary Care network meetings and practice managers meeting, dental, optometry and pharmacies operational group meetings across the 9 places to promote FTSU and gain understanding of the FTSU process they have in place and give support with developing an FTSU process where none exist.
- the development of a charter/terms of reference for our FTSU Ambassadors’ network to support our ambassadors with carrying out their roles efficiently (raising awareness, signposting to FTSU Guardians and promoting FTSU) and managing expectations and requirements involved in volunteering as an FTSU Ambassador.
- work is underway with the Communications team on creating a platform on the staff hub for staff to share their good stories and a monthly FTSU newsletter of how speaking up is helping us to continuously improve from FTSU case studies.
- the improvement to the SARs process following a FTSU concern raised.
- refresher/new FTSU Ambassador training session for our old and new Ambassadors in December 2024, following the first training session in 2023 when the FTSU Ambassadors network was launched.

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 2024/25 Q1, Q2 and Q3. Q4 data is only due after March 2025.

Total Numbers of cases 2024/25	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25
29	7	10	12	

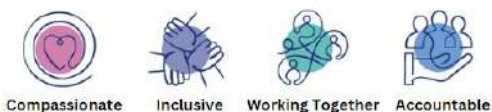
5.10 Clarification has been received that ICB reporting figures should only include those cases raised by employees or workers of the ICB and which relate to the ICB.

5.11 The number of FTSU cases reported has steadily increase as we continue to raise the profile of FSTU across the ICB and in comparison, with the other ICBs in the northwest region, C&M ICB FTSU process is continuously improving.

*ICB	Quarter (2024 /2025)	Number of cases brought to Freedom to Speak Up Guardians	Number of cases raised anonymously	Number of cases with an element of patient safety / quality	Number of cases with an element of worker safety or wellbeing	Number of cases with an element of bullying or harassment	Number of cases with an element of other inappropriate attitudes or behaviours	Number of cases where people indicate that they are suffering disadvantageous and/or demeaning treatment (detriment) as a result of speaking up
NHS C&M	Q1	7	0	1	5	1	0	0
NHS C&M	Q2	10	1	1	7	0	1	0
NHS GM	Q1	14	0	0	0	4	0	0
NHS GM	Q2	11	0	0	0	0	0	0
NHS L & SC	Q1	12	2	1	2	3	6	2
NHS L & SC	Q2	6	2	1	0	1	2	1

*Benchmark data against other ICBs in the northwest region with up to 5,000 workers. Q3 data not included as data is not available yet on the National Guardians Office site, as Q3 data submission opened 6th January 2025 and closes 10th February 2025.

NB: ICB stands for Integrated Care Board
 NHS C&M stands for NHS Cheshire and Merseyside
 NHS GM stands for NHS Greater Manchester
 NHS L & SC stands for NHS Lancashire and South Cumbria



Leading integration through collaboration

5.12. The nature of the themes from speaking up and changes made as a result within C&M ICB

Themes	Lessons (identified/learnt)	Action taken	Locality/team	Feedback from staff speaking up
Q1 & Q3 -Policies and processes (such as Subject Access Request - SARS, Mutually Agreed Resignation Scheme - MARS, career break, recruitment processes and flexible working policy) not being followed resulting in poor working environment impacting on staff wellbeing and work output.	Subject Access Request (SARS) and communication process need reviewing. Agreed policies and processes should be followed.	Escalated to highlighted leads, including Executive FTSU leads and chief people officer. The SARS process was reviewed and improved. Ongoing collaboration work in reviewing ICB policies and Programmes with the HR team.	Corporate Affairs & Governance, People Team and All Age Continuing Care Teams	'Pleased, felt valued, appreciated and taken seriously and happy with quick response, however felt confused and frustrated with the gleaning information stage from the leads and the way response was feedback.' 'Need to create a psychological safe environment for staff to speak up and leaders to see it as an opportunity to learn and improve and not for adversary / personal reactions. Suggestions around FTSU buddy for support.'
Q1, Q2 & Q3 - Gaps in communication and support from managers to staff, check ins to be proactive and not reactive. Lack of clarity on roles, new systems and ways of working and induction/guidance from managers. Managers not feeling supported enough to deal with staff issues around wellbeing.	Communication and managerial support for staff needs improving. Bespoke induction is needed for new staff. Training on having difficult conversations needed for managers.	Escalated to highlighted leads, and HR. ICB now has an induction programme which includes information about our FTSU process. We have an FTSU page on the staff hub that provides further information on speaking up. Exploring ways to ensure managers can access FTSU e-learning on Listen up and Follow-up for senior leaders	All Age Continuing Care, Medicines Management and Community Assessment Teams	'Concerns were raised in a safe way, clear FTSU process, easy to use and prompt response, glad and thankful and sometimes leads' responses to concerns can be vague and still work to be done on getting our organisation to speaking up as business as usual.' 'Fear it could have a negative impact on my job and potential future roles.' 'Felt supported, heard and acknowledged. Leads' response form helped to ask the right questions and receive right response.'



Compassionate



Inclusive



Working Together



Accountable

Themes	Lessons (identified/learnt)	Action taken	Locality/team	Feedback from staff speaking up
		to support their staff more adequately. Other training programmes are being rolled out by the Organisational development director to support managers.		
Q1, Q2 & Q3 - Shortage of staff, stress & anxiety, staff member behaving inappropriately, some feeling bullied.	Due to staff working remotely, this might present as a barrier to regular contact with the leadership team & need to work on supporting their staff to feel able to raise concerns locally and provide timely support. Awareness of staff anxieties around being typed and ensuring a smoother transition, induction and creating a psychological safe working environment for staff and timely action on concerns raised.	Escalated to highlighted leads, FTSU Executive leads, NHSE and signposted to HR and bullying and harassment policy	Quality and Safety Improvement, Medicines Management and Finance team	‘Work still needs to be done in promoting a ‘We are one’ as an ICB despite the 9 different places and clarity is needed to address issues raised more fully.’ ‘Helpful to talk things through, Temitayo (FTSU Guardian lead) was helpful to talk to and double check summary of concern notes with staff before escalating.’ ‘Felt uncomfortable and unsure they used the right route to raise their concern.’ ‘I’m glad I shared my experiences. It was really getting me down and severely affecting my mental health. Temitayo was there to listen straight away and took my concerns on board. The process was streamline and easy to follow.’

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 evidence outcomes/lack of trust**— fear of going through with speaking up by a percentage of ICB staff has been identified. The FTSU Guardian lead with the help of the communications team and staff who have used the FTSU process and given consent to share their stories to create a ‘you said, we did’ section on the staff hub page in Q4 and show the difference it has made with continuous improvement in the ICB thus building trust and confidence in the FTSU process.

The FTSU staff survey is repeated this January 2025, this will help to measure any changes or improvement.

7.2 **Lack of understanding of line managers of their part in making speaking up business as usual** - oftentimes staff have spoken up to line managers and no action or feedback given. Some of the main learning points from Q1, Q2, and Q3 data include:

‘Training on having difficult conversations is needed, gaps in communication and support from managers to staff, check ins to be proactive and not reactive; Agreed policies and processes need to be followed, as this impacts on staff wellbeing and work outputs if ignored, resulting into a poor working environment’.

The FTSU Guardian lead with the support of the senior executives in partnership with all ICB line managers to explore what support is needed and educate on how to create a psychological safe working environment that welcomes speaking up and give feedback and take action when concerns are raised to them.

8. Communication and Engagement

8.1 Communication and engagement have taken place throughout the year including ‘We are One’ sessions, FTSU Guardian Lead attending local staff meetings, new staff induction organisation orientation programmes, 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 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 and empowering line managers to support their staff to speak up and make speaking up business as usual.
- 10.2 A roll out of the level 2 FTSU training for managers and level 3 FTSU training for senior leaders.
- 10.3 Actions outlined in the action plan (**Appendix Three**) will be progressed and updates provided through to the ICB's People Sub-Committee.
- 10.4 Further reflection and discussion on how the Board can support speaking up within the organisation will take place during a future Board development session on the 13th of February 2025.
- 10.5 The organisation is required to complete the self-assessment and reflection tool every two years. The ICB is required, by January 2026, to use the FTSU Self-Assessment tool help the board reflect on its current position and the improvement needed to meet the expectations of NHSE and the NGO. 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.
- 10.6 The ICB will continue to focus on increasing awareness and removing any barriers to speaking up, linked to wider cultural improvement work. The FTSU Guardian lead with the help of the FTSU Ambassadors and FTSU Summit will

continue to promote speaking up across the ICB and engage both staff and senior leaders in making speaking up business as usual.

- 10.7 The C&M ICB is working on supporting Freedom to Speak Up in Primary Care to ensure that FTSU arrangements are in place for system partners in Primary Care according to the NHSE letter to ICBs in October 2024. The FTSUG lead has attended and attending Primary Care Network meetings and practice managers meetings, dental, optometry and pharmacies operational group meetings across the 9 places to promote FTSU and gain understanding of the FTSU process they have in place and give support with developing an FTSU process where none exist.
- 10.8 In our commitment to make speaking up business as usual within our ICB, we are exploring technological solutions for speaking up – a step forward from the FTSU Anonymous form that sits on the FTSU staff hub page. An FTSU icon that can show on desktops which enables straight through processing of a concern – much like a phishing icon and the FTSUG would be alerted and the data behind the concerns could be logged and used for triangulation. Opportunities to explore this and build this into our Ulysses and the data reporting through Datix is being discussed with IT and MLCSU.
- 10.9 The FTSU staff survey is being completed again by all ICB staff between 13th-31st January 2025, following the first and initial completion in January 2024. The results from the survey will be presented at the February FTSU Summit and help inform our FTSU culture.

11. Officer contact details for more information

Temitayo Roberts FTSU Guardian Lead
Temitayo.Roberts@cheshireandmerseyside.nhs.uk

12. Appendices

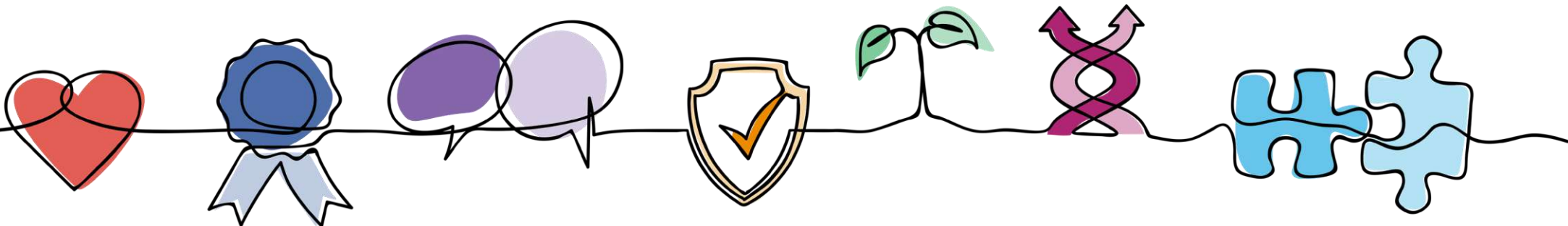
Appendix One: FTSU Self-Assessment – NHS Cheshire & Merseyside (January 24)

Appendix Two: FTSU Action Plan – NHS Cheshire & Merseyside (January 24)

Appendix Three: FTSU Action Plan – NHS Cheshire & Merseyside (December 24)

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
<p>Enter summarised evidence to support your score.</p> <p>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.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	
<p>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.</p>	
<p>2. Support recruitment of dedicated Guardian.</p>	
<p>3. Further face to face engagement with NED and Guardian and FTSU Ambassadors</p>	

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
<p>Enter summarised evidence to support your score.</p> <ul style="list-style-type: none"> • 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 	
<p>High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)</p>	
<p>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.</p>	

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
<p>Enter summarised evidence to support your score.</p> <p>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.</p> <p>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.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	
<p>5. Review of the organisation’s cultural metrics and development of an improvement plan where needed</p>	
<p>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</p>	

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
<p data-bbox="152 667 931 705">Enter summarised evidence to support your score.</p> <p data-bbox="152 740 2085 852">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.</p>	
<p data-bbox="152 979 1413 1018">High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	
<p data-bbox="152 1053 1037 1091">7. Recruitment of dedicated FTSU Guardian (planned for Q4)</p>	

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
<p>Enter summarised evidence to support your score.</p> <p>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.</p>	
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
<p data-bbox="152 485 931 520">Enter summarised evidence to support your score.</p> <p data-bbox="152 560 1968 632">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.</p> <p data-bbox="152 671 1167 703">We cannot evidence effectiveness of our communications mechanisms.</p> <p data-bbox="152 743 2024 815">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.</p>	
<p data-bbox="152 874 1413 909">High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	
<p data-bbox="152 946 1912 981">9. Consider how we can measure effectiveness of communications mechanisms – link to communications team for support.</p>	
<p data-bbox="152 1034 1335 1069">10. Continue to promote positive stories and look to use local cases when available.</p>	

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
<p>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.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	
<p>12. Ensure lessons learnt from speaking up are shared across organisation and incorporated into cultural improvement programme.</p>	

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
<p>Enter summarised evidence to support your score.</p> <p>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.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	
<p>15. Continue to link with external colleagues to use good practice to develop our own approach.</p>	

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
<p>Enter summarised evidence to support your score.</p> <p>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.</p>	
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
<p>Enter summarised evidence to support your score.</p> <p>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.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	
<p>16. Agree performance and development objectives with the newly appointed Guardian.</p>	

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
<p>Enter summarised evidence to support your score.</p> <p>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.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	
<p>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.</p>	

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
<p>Enter summarised evidence to support your score.</p> <p>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.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	
<p>18. Continue to identify actions to reduce barriers and evaluate the impact of any actions taken.</p>	

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
<p data-bbox="152 679 931 715">Enter summarised evidence to support your score.</p> <p data-bbox="152 756 2056 900">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.</p>	
<p data-bbox="152 957 1415 992">High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	
<p data-bbox="152 1027 1966 1098">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.</p>	

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
<p>Enter summarised evidence to support your score.</p> <p>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.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	
<p>(14) Cultural improvement work to be clearly defined.</p>	

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
<p>Enter summarised evidence to support your score.</p> <p>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.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	
<p>20. Ensure measurement of how safe and confident people feel to speak up as part of staff experience dashboard.</p>	

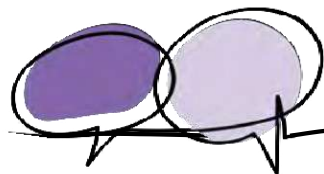
Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	2
We have we evaluated the content of our guardian report against the suggestions in the guide	2
Our guardian(s) provides us with a report in 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
<p>Enter summarised evidence to support your score.</p> <p>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.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	
<p>(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.</p>	



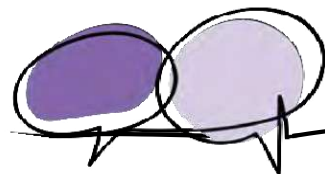
Freedom to Speak Up Action Plan

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.

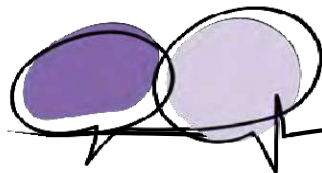
ID	Action	Timescale	Lead	Progress	RAG
1.	Ensure all staff are aware of FTSU provisions, understand the role of FTSU and their responsibility to speak up. Promote the variety of ways that staff can speak up about any concerns they may have and encourage a culture of accountability and openness.	May 23	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 4 th 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 9 th 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.	



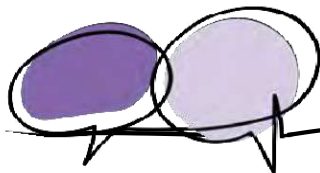
ID	Action	Timescale	Lead	Progress	RAG
21. *	Ensure measurement of how safe and confident people feel to speak up as part of staff experience dashboard.	July 24	VW	Staff experience dashboard under development as part of development of improved workforce dashboard.	
22.	Develop programme of activities 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

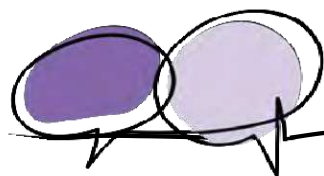




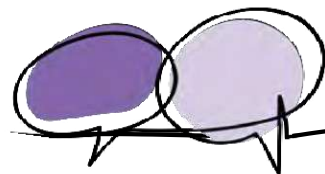
Freedom to Speak Up Action Plan

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.

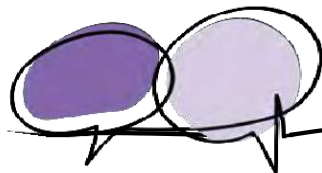
ID	Action	Timescale	Lead	Progress	RAG
1.	Ensure all staff are aware of FTSU provisions, understand the role of FTSU and their responsibility to speak up. Promote the variety of ways that staff can speak up about any concerns they may have and encourage a culture of accountability and openness.	October 2024	TR	FTSU update included in We Are One – May, June, July (FTSU F2F Ambassador network meeting) and on electronic pay slips. Staff Hub (as above) and external website reviewed and FTSU policy updated and aligned with the NGO's office guidelines. Communications materials and templates developed and shared across Places/teams – 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.	April 2024	TR	Procedure developed and constantly reviewed following on from FTSU feedback received.	Ongoing
3.	Promote FTSU e-learning for all staff and enhanced FTSU training for leaders.	December 2024	TR	NGO training implemented in June 23, current compliance as of 17th of December 2024 is 90.68%. Additional training available for managers. Uptake of training monitored in monthly workforce reports and promoted via staff comms, FTSU promotion work and FTSU page.	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.	October 2024	TR	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. FTSU 'Listen Up'	Ongoing



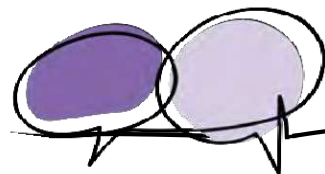
ID	Action	Timescale	Lead	Progress	RAG
				and 'Follow Up' mandatory training for managers and senior leaders. TR highlights this to all staff at FTSU promotional work she does across the C&M ICB 9 Places.	
5.	Identify lead NED for FTSU.	Achieved	TR	Erica Morriss confirmed as FTSU NED	
6.	Development of FTSU Strategy outlining ambition for speaking up.	Achieved	TR	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 approved by People Committee July 23. Copy of the Strategy available on the Staff Hub FTSU page and external website.	
7.	Develop an FTSU Ambassador Network, led by the FTSU Guardian	Achieved	TR	FTSU Ambassador role profile developed. Continuous call out for additional Ambassadors on WAO/Weekly Bulletin, FTSU promotion work across Places and teams. 22 current Ambassadors – contact directory developed and promotional materials (poster, email signature). Had first F2F FTSU Ambassador network meeting on the 9 th of July 2024, as meetings have been on Teams and a refresher training planned for December 2024 which will be a hybrid meeting.	
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.	October 2024	TR	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. Achieved establishment but work is needed with the reviewing of triangulation of data. Exploring technological solutions for speaking up – a step forward from the FTSU Anonymous form that sits on the FTSU webpage. An FTSU icon that can show on desktops/laptops which enables straight through processing of a concern - much like a phishing icon and the FTSUG would be alerted and the data behind the concerns could be logged and used for triangulation. Opportunities to explore this and build this into our Ulysses and the data reporting through Datix is being discussed with IT and MLCSU.	Ongoing



ID	Action	Timescale	Lead	Progress	RAG
9.	Promotion of Speak Up Month in October with the theme of 'Power of Listening'	October 2024	TR	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 Ambassadors network and Summit, focus on listening to concerns raised, to enable all workers to feel safe and confident to speak up, feel valued, #SpeakUpPledges, WAO – Wear Green Wednesdays to support Speak Up, focus on no detriment #SpeakUpForSafety, introducing both new and old Ambassadors, #Listen Up, #HereToListen 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.	February 2025	TR	Short FTSU survey (4 questions) launched in January 2024 to test if staff know about FTSU, if they know how to speak up through FTSU, and how they feel about using FTSU is due to be repeated in January 2025 to check the impact FTSU is having. Results to be reviewed and any actions arising to be identified and incorporated into plan.	
11.	Review effectiveness and measure impact of current FTSU communications.	August 2024	TR	Review comms data/metrics to understand level of staff accessing materials and reach of current comms.	Continuously improving
12.	Identify positive staff stories to promote the benefits of speaking up and share the experience of staff who have spoken up.	March 2025	TR	Using national resources and our staff stories being put together to be used in a rolling programme of comms.	
13.	Recruitment of dedicated Guardian.	Achieved	TR	Temitayo Roberts, lead Freedom To Speak Up Guardian is in post.	
14.	Development of a culture improvement plan responsive to the needs of a new organisation and inclusive of our commitment to a just culture.	March 2025	TR/ TS/ EM/AM/S B/MC	5 Point action plan: 1) Awareness raising on FTSU agenda across ICB including events; branding; lunch and learn sessions; drop ins; ICB Values – compassionate Leadership module; Network engagement etc (TR/TS) 2) Skills development (training courses) on FTSU process and application to be integrated into 'We Have a voice' of the People Promise on	



ID	Action	Timescale	Lead	Progress	RAG
				<p>the staff hub (TR/SB) Such as Mandatory E Learning Programme, Awareness Sessions and sessions for bespoke FTSU roles.</p> <p>3) Leadership development to include work with Board, Exec and SLF audience on clarity re role and responsibilities under FTSU to create a culture for FTSU in line with ICB culture operating model (TS, MC)</p> <p>4) System and process redesign –addressing any organisation cultural friction between FTSU and organisational systems and processes that may inadvertently hinder a learning organisation from a FTSU lens ie BAF ‘reputational risk’ system and process; near misses processes, comms systems and processes etc (TR, EM, TS)</p> <p>5) Governance – review and monitor leadership accountability and assurance for creating psychological safety for FTSU (EM, TS and MC)</p>	
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).	Ongoing	TR	TR meet with FTSU Ambassadors quarterly and FTSU Guardians monthly and often attend Staff Engagement Group meetings and various staff team meetings, where possible to collectively identify actions to reduce barriers to FTSU.	
16.	Increase profile of NED through face-to-face engagement with Ambassadors	Ongoing	EM	EM attends the FTSU Ambassador network team meetings and arrangement is being made for a face-to-face engagement.	
17.	Ensure FTSU features in new induction programme which includes local team-based induction requirements	November 2024	SB / TR	New induction programme and approach has been launched with the first orientation session taken place in October 2024. Information and contacts in respect of FTSU included as part of the induction pack and orientation session. Attendance of a Guardian or Ambassador at each session.	
18.	Dedicated FTSU session at Senior Leadership Forum.	October 2024	TS/TR	TR raised the awareness and importance of FTSU to senior leaders during the SLF meeting in September 2024.	

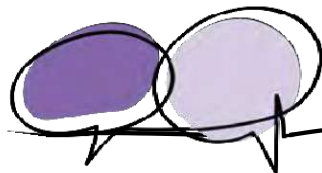


ID	Action	Timescale	Lead	Progress	RAG
19.	Personal pledges from senior leaders to demonstrate commitment to supporting speaking up. Leaders to be visible and vocal (as part of normal business) in demonstrating that they welcome and encourage speaking up.	October 2024	EM/TR/C D/AM	As part of the freedom to speak up month promotion in October, invitation to complete the FTSU pledges was sent out to all staff and senior leaders, and this was featured on the staff hub FTSU page.	
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.	March 2025	TS/MC/A M/TR	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.	
21.	Ensure measurement of how safe and confident people feel to speak up as part of staff experience dashboard.	January 2025	AM/SB	The development of a wider suite of staff experience measures is under development to include the new Pulse Survey. Planned for Q4.	
22.	Develop programme of activities for Speak Up Month - October 24	October 2024	TR	Concluded work for Speak Up month in October with the theme: 'power of listening', #HereToListen, #ListenUp, #SpeakUpPledges.	
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.	January 2025	TR/TS	FTSU data are being collated, as C&M ICB staff have only started to raise FTSU concerns since lead Guardian in post. TR working with communications team to develop 'a you said, we did' section on the FTSU page on the staff hub	
24.	Review first year of FTSU Summit. Reflect on role of Summit and developments in relation to FTSU including effectiveness of its role in triangulating data, considering lessons learned and sharing good practice across the organisation.	October 2024	EM/TR	Review of the FTSU SUMMIT 'TOR' at the August meeting to see how activities are aligning.	

Key

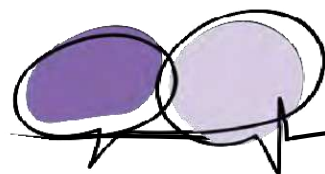
* Key actions / milestones

RAG	Description
	Completed



	In progress / On track
	Overdue / behind schedule
	Not yet started

Initial	Name / Role
TR	Temitayo Roberts, 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
AM	Andrew Maloney, Associate Director of Workforce
CD	Chris Douglas, Executive Director of Nursing & Care and Executive FTSU Lead
EM	Erica Morriss, Non-Executive Director, FTSU Lead



Meeting of the Board of NHS Cheshire and Merseyside

30 January 2025

Board Assurance Framework 2024-2025 and Quarter Three Update Report

Agenda Item No: ICB/01/25/20

Responsible Director: Clare Watson
Assistant Chief Executive

Board Assurance Framework 2024-2025 and Quarter Three Update Report

1. Purpose of the Report

- 1.1 The purpose of the report is to present the quarter three update of the Board Assurance Framework (BAF).

2. Executive Summary

- 2.1 The 2024-25 BAF and principal risks were approved by the Board in July. 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 1 critical risk, 5 extreme risks and 4 high risks. Of these, 7 are at the agreed target for 2024-25 and the focus will be on assurance that controls remain effective and on continuing to progress actions to further mitigate the risk over the longer term. The remaining 3 remain above the agreed target for 2024-25. Despite the actions being taken it is anticipated that reductions in P3 and P5 will take longer to achieve and therefore revisions to the current year targets are proposed.

- 2.3 The critical risk is:

- 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 critical (20).

- 2.4 Since the November report:

- P7 - The Integrated Care System is unable to achieve its statutory financial duties **current rating has reduced** from critical (20) to extreme (16). The potential impact has reduced due to an improving financial position, and it is proposed to amend year-end target score from 15 to 16 to reflect this.
- 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. As a result of lost opportunities due to industrial action, recent cyber attacks and urgent care pressures it is not now anticipated that a reduction in the score will be achieved by year-end and the target score **has been increased** to 15.
- P5 - Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals



Compassionate



Inclusive



Working Together



Accountable

and social care) results in patient harm and poor patient experience. As a result of current demand levels, it is not now anticipated that a reduction in the score will be achieved by year-end and the target score **has been increased** to 20.

- 2.5 The report and appendices set out the controls that are 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 are provided through the work of the Committees and through Board reports over the course of the year.
- 2.6 Acceptable assurance is available in relation to 5 of the principal risks but further assurance is required in respect of the remaining 5 and further details are provided in section 9.9 and appendix two.

3. Ask of the Board and Recommendations

3.1 The Board is asked to:

- **APPROVE** the reduction in the current risk rating and amended target for P7, and the increases in the target scores for P3 and P5 as described in section 2.4.
- **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 BAF 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 2024-25 were approved for adoption by the Board in July and form the basis of the Board Assurance Framework 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 Assurance Framework (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**

- 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.

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.

9. Risks

9.1 The quarter 3 BAF is summarised in the heat map below:

ID	Risk	Inherent			Current (Q3)			Target 2024-25			Risk Appetite (Optimal)	
		L	I	R	L	I	R	L	I	R	Rating	Timescale
P1	Health inequalities	4	5	20	3	5	15	3	5	15	High (8)	2027-28
P3	Elective care	5	5	25	3	5	15	2	5	15	Moderate (5)	2026-27
P4	Major quality failures	3	5	15	2	5	10	2	5	10	Moderate (5)	2026-27
P5	Urgent & emergency care	5	5	25	4	5	20	3	5	20	Moderate (5)	2026-27
P6	Primary care access	5	4	20	3	4	12	3	4	12	Moderate (6)	2025-26
P7	Statutory financial duties	5	5	25	4	4	16	4	4	16	High (8)	2026-27
P8	Provider sustainability	4	4	16	3	4	12	3	4	12	Moderate (6)	2026-27
P9	ICS workforce	4	4	16	4	4	16	4	4	16	Moderate (6)	2026-27
P10	Focus on long term strategy	4	4	16	3	3	9	3	3	9	Moderate (6)	2025-26
P11	Digital infrastructure	5	4	20	4	4	16	4	4	16	High (8)	2025-26

9.2 The key changes proposed from the quarter 2 position are as follows:

P3 – an increase in the target score from 10 to 15, reflecting lost opportunities due to industrial action, recent cyber attacks and urgent care pressures.

P5 – an increase in the target score from 12 to 16, reflecting current demand levels.

P7 – a reduction in the current score from 20 to 16, reflecting an improvement in the financial position.

9.3 A summary of the principal risks and high-level mitigation strategies is provided at appendix one. Further detail in respect of each risk, including the assessment and scoring rationale, current controls and assessment of their effectiveness, gaps identified, planned actions and progress, assurances provided and a

current position statement in relation to progress towards target, is provided in the individual risk summaries at appendix two.

- 9.4 There are currently 1 critical risk, 5 extreme risks and 4 high risks. Of these, 7 are at the agreed target for 2024-25 and the focus will be on assurance that controls remain effective and on continuing to progress actions to further mitigate the risk over the longer term. The remaining 3 remain above the agreed target for 2024-25. Despite the actions being taken it is anticipated that reductions in P3 and P5 will take longer to achieve and therefore revisions to the current year targets are proposed.
- 9.5 The majority of the planned actions are on track, but there is one action assessed as problematic - delivery remains feasible, actions not completed, awaiting further interventions. This is:
- 9.5.1 In relation to P7 – statutory financial duties, action to conclude and secure agreement to the medium-term financial strategy. This reflects the scale of the challenge and the work still to complete in testing and finalising delivery metrics, timescales and quantifying associated financial impact for recovery programmes.
- 9.6 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. The ICB's committees provide scrutiny and challenge of risk independent of the management line and are an important source of 2nd line assurance to the Board. Their discussion and decisions in relation to BAF risks were summarised in the chair's highlight reports considered by the Board on 28/11/24 and appearing elsewhere on this agenda.
- 9.7 In addition the following assurance reports have been provided to the Board during quarter three:
- 9.7.1 Director of Nursing Report – 28/11/24 (P4)
- 9.7.2 Integrated Performance Report – 28/11/24 (P3, P4, P5, P6, P9)
- 9.7.3 Finance Report – 28/11/24 (P7)
- 9.7.4 Shaping Care Together – establishment of a Joint Committee with Lancashire and South Cumbria ICB – 28/11/24 (P8)
- 9.7.5 Primary Care Access Recovery Plan Update – 28/11/24 (P6)
- 9.7.6 Intensive and Assertive Community Mental Health Care – 28/11/24 (P1, P4, P9)
- 9.7.7 Update on Physical Health Checks in Severe Mental Illness – 28/11/24 (P1, P4)
- 9.8 A summary of the assurance ratings for each of the principal risks is provided below:

ID	Risk	Committee	Current Score (Q3)	Controls					Assurance Rating
				Policies	Processes	Plans	Contracts	Reporting	
P1	Health inequalities	S&T	15	G	G	G	G	G	Acceptable
P3	Elective care	Q&P	15	G	A	G	G	G	Acceptable
P4	Major quality failures	Q&P	10	A	A	A	G	G	Acceptable
P5	Urgent & emergency care	Q&P	20	G	A	A	G	A	Partial
P6	Primary care access	SPCC	12	G	A	A	G	G	Acceptable
P7	Statutory financial duties	FIRC	16	G	G	A	A	G	Partial
P8	Provider sustainability	S&T	12	G	G	A	A	A	Partial
P9	ICS workforce	FIRC	16	A	A	A	G	A	Partial
P10	Focus on long term strategy	Execs	9	G	G	A	A	G	Acceptable
P11	Digital Infrastructure	S&T	16	A	A	A	A	A	Partial

9.9 There are a number of risks assessed as having only partial assurance - some confidence in delivery of existing mechanisms / objectives, some areas of concern. These are:

P5 where key performance measures indicate that, despite existing controls, service delivery is not yet meeting required national and local standards.

P7 where additional assurance is required that there is an agreed and approved ICS medium-term financial strategy to address the financial deficit.

P8 where additional assurance is required that there is a credible case for change and sustainable transformation plans in relation to a number of fragile services.

P9 where further assurance is required regarding action planned to address priority gaps in control with the reduced resource available.

P11 where additional assurance is required regarding organisation and system level cyber security compliance and risk, and robust plans to address any identified gaps.

Further detail is provided in the risk summaries at appendix two.

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 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 adversely 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 two.

12.2 Principal risk P1 has the potential to impact on health inequalities. The mitigations in place and planned are described in more detail in the risk summaries at appendix two.

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 two. 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: BAF Risk Summaries

Board Assurance Framework 2024/25 – 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 2024-25	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	Strategy & Transformation Committee Clare Watson	4x5=20	3x5=15	No change	3x5=15	Assurance on progress and effectiveness of delivery of All Together Fairer: Our Health and Care Partnership Plan. Focus remains the building of the foundations that would lead to a reduction in health inequalities over the longer term.
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	Quality & Performance Committee Anthony Middleton	5x5=25	3x5=15	Target increased from 10 to 15	3x5=15	Further action to strengthen controls. Key actions are the Elective Recovery Team and increasing diagnostics capacity through Community Diagnostic Centres and elective capacity through elective hubs.

Principal Risks	Responsible Committee & Executive	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Change from previous quarter	Target Risk Score 2024-25	Priority Actions / Assurance Activities
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	2x5=10	Significant controls in place. Priority will be to continue to embed and strengthen controls and 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	Target increased from 15 to 20	4x5=20	Urgent Care Recovery Programmes in 5 areas are focused on the key objective of eliminating corridor care in 24-25, as well as reducing the number of hospital attendances and admissions and improving discharge pathways and processes.
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	3x4=12	No change	3x4=12	Assurance on progress and effectiveness of delivery of Primary Care Access Recovery Plan and Dental Improvement Plan.
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 Mark Bakewell	5x5=25	4x4=16	Score reduced from 20 to 16. Target increased from 15 to 16.	4x4=16	Key aim of Recovery Programme is to improve use of resources. Key further action is to secure agreement to the Medium-Term Financial Strategy.

Principal Risks	Responsible Committee & Executive	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Change from previous quarter	Target Risk Score 2024-25	Priority Actions / Assurance Activities
P8: The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services	Strategy & Transformation Committee Rowan Pritchard-Jones	4x4=16	3x4=12	No change	3x4=12	Further action to implement and strengthen controls. Ongoing action to progress the development of case for change across multiple programmes.
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	4x4=16	No change	4x4=16	Further action to implement and strengthen controls. Key actions are to develop and enhance system workforce planning and scaling up of Peoples Services.
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	Assurance on progress and effectiveness of delivery of All Together Fairer and Joint 5-Year Forward Plan.
P11: The ICB is unable to address inadequacies in the digital infrastructure and related resources leading to disruption of key clinical systems and the delivery of high quality, safe and effective health and care services across Cheshire and Merseyside.	Strategy & Transformation Committee Rowan Pritchard-Jones	5x4=20	4x4=16	No change	4x4=16	Further action to implement and strengthen controls. Key actions are C&M wide baseline analysis and benchmarking, identifying and progressing opportunities for collaboration and standardisation, and identifying and addressing supply chain risks.

Appendix Two – BAF Risk Summaries

ID No: P1 Risk Title: The ICB is unable to meet its statutory duties to address health inequalities				
Risk Description (max 100 words)	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 and wellbeing is shaped by 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 multiple organisations, agencies and communities covered by the ICB.			
Senior Responsible Lead	Operational Lead	Directorate		Responsible Committee
Clare Watson	Prof. Ian Ashworth	Assistant Chief Executive		Strategy & Transformation
Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequality, Improving Outcomes and Access to Services	Transformation	C – beyond 12 months	Principal	Manage
Date Raised		Last Updated		Next Update Due
13/02/23		18/12/24		16/12/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	4	3	3	3		3	31/03/25	Our longer-term ambition is to moderate to a (2x4=8) level of risk but will only be achievable over 3-4 years due to resource allocation and capacity. This equally applies to systemwide inequalities due to financial pressures and capacity.
Impact	5	5	5	5		5		
Risk Score	20	15	15	15		15		

Rationale for score & progress in quarter (max 300 words)	<p>There is potential for a major reduction in health outcomes and/or life expectancy and major increase in the health inequality gap in deprived areas or for socially excluded groups (impact 5). Current controls are effective in reducing the likelihood, but this is still possible (3). There have been delays in mitigating action due to financial constraints and any further delay is likely to increase the risk score to 20 (critical). Planned mitigation is focused on delivering the All Together Fairer: Our Health and Care Partnership Plan, including securing health inequalities investment allocation. The planned actions will be affected by the ICB financial review, some delay to some aspects of work, will be applied to support the 2024-25 financial challenges. The delay would be for the remainder of this financial year. As a result, the completion dates for All Together Fairer and Health Inequalities approaches with place-based partnerships and implementation of Population Health sub-groups have been delayed. Our focus remains on the building of the foundations that would lead to a reduction in health inequalities and contribute to our ambition of a score of 8, but this is now expected to take longer over the next 3-4 years. It is vital that the ICB Recovery Programme consistently reviews opportunities to reduce demand and avoidable admissions, whilst acting on reducing the impact of health care inequalities, as well as considers the implications of any decommissioning on the Health Inequalities in relation to the associate populations.</p>
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Current Key Controls		Rating
Policies	Constitution, membership & role of HCP Partnership Board, 'All Together Fairer;(Marmot Review)' Core 20+5 stocktake, Prioritisation Framework, Public Engagement / Empowerment Framework.	G
Processes	Strategic planning, consultation & engagement, financial planning, Population Health Partnership group support, advice, and scrutiny of the Population Health Programme.	G
Plans	All Together Fairer: Our Health and Care Partnership Plan , HCP Interim Strategy, 5 Year Joint Forward Plan, Financial Plan (including ringfenced health inequalities funding) approved by HCP, Joint Health, and Wellbeing Strategies	G
Contracts	NHS Trust contracts (including contract schedule to support reducing health inequalities)	G
Reporting	C&M HCP Partnership Board, Population Health Partnership Group, Place-Based Partnership Boards, Strategy & Transformation Committee, ICB Board.	G
Gaps in control		
<p>Gaps in controls Lack of long-term sustainable funding across a number of programmes that are contributing to Population Health Priorities. A reduced investment in Health Inequalities funding in year 24/25 from the ICB This will lead to a delay in some programme commencement dates until April 2025.</p>		

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Finalise Joint 5-year Forward Plan aligned to All Together Fairer			Neil Evans	01/10/24	Complete
Secure ICB ring-fenced Health Inequalities budget allocation			Clare Watson	31/03/25	Complete
Agree All Together Fairer and Health Inequalities approaches with place-based partnerships (incl allocation, guidance & reporting)	Reduce	Reduce	Ian Ashworth	31/03/25	On Track
Implement Population Health Group sub-groups aligned to population health programme plan on a page	Reduce	Reduce	Population Health Consultants	31/03/25	On Track
Development of performance framework, underpinning data & intelligence to enable demonstration of progress.	Reduce	Reduce	Cerriann Tunnah	31/03/25	On Track
NHSE recurrent funding secured for both the Familial Hypercholesterolemia and CVD Prevention services – confirmed at S&TC.			Julie Kelly	21/11/24	Complete

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme, or critical)

Assurances available to lead committee and ICB Board			
Source	Planned Date /Frequency	Date/s provided	Assurance Rating
ICB Board approval to Joint 5 Year Forward Plan	October 2024	1/10/24	Acceptable
Progress reports to C&M HCP Board on delivery & implementation of programmes and projects.	Quarterly	26/09/24	
Progress reports to Strategy & Transformation Committee on delivery & implementation of programmes and projects.	Bi-monthly	Bi-monthly -Apr to Nov	
Core20+5 Health Inequalities Stocktake for NHSE/I reported to Population Health Partnership Group & C&M HCP Board.	Quarterly	QT 1 & QT 2 submitted QT3 in production	

		for submission Jan 2025	
Gaps in assurance			
<p>Limitations on scale and pace of investment due to challenging financial environments for all partners. Population Health Group Sub-Groups to develop where required. Programme metrics and impact reporting require review.</p>			
Actions planned	Owner	Timescale	Rating
Secure ICB ring-fenced Health Inequalities budget allocation – 2025-26	Clare Watson	31/03/25	On Track
Review of Programme reporting metrics and Impacts	Ceriann Tunnah	31/12/24	On Track
Develop assurance role of Population Health Group Sub-Groups	Ian Ashworth	28/02/25	On Track

ID No: P3	Risk Title: 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			
Risk Description (max 100 words)	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, including industrial action, and urgent and emergency care pressures, impact on the available capacity in the system to tackle the longest waits. 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.			
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		12/12/24		12/01/2025

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	3	3	3		3	31/3/25	The ICB has a low tolerance for risks impacting patient safety and the aim is to reduce to a moderate/low level acknowledging that this will take 2-3 years to achieve in line with national improvement trajectories.
Impact	5	5	5	5		5		
Risk Score	25	15	15	15		15		
Rationale for score & progress in quarter (max 300 words)	There is potential for multiple deaths or irreversible health effects, or harm to more than 50 people, and gross failure to meet national standards (impact 5). Current controls are effective in reducing the likelihood to possible (3). Elective Recovery, Diagnostics and Cancer Programmes are focused on increasing activity, faster diagnosis and treatment and reducing long waits. As a result of lost opportunities due to industrial action, recent cyber attacks and urgent care pressures it is not now anticipated that a reduction in the score will be achieved by year-end and the target score has been increased from 10 to 15.							

Current Key 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, diagnostics mutual aid	A
Plans	C&M Operational Plan, Elective Recovery Programme and Plans, Diagnostics Programme and Plans including Community Diagnostics Centres, Cheshire & Merseyside Cancer Alliance work programme, Place Delivery Plans, Winter Plan, EPRR	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

Scale and frequency of potential future industrial action unknown and may impact on workforce capacity.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
CMAST Elective Recovery Improvement Programme	Reduce	Target impact remains same	Anthony Middleton	2024/25	On Track
Increase diagnostics capacity through CDCs and elective capacity through elective hubs	Reduce	As above	Anthony Middleton	2024/25	On Track
Cancer Alliance targeted investment and support to priority cancer pathways	Reduce	As above	Anthony Middleton	2024/25	On Track
Delivery of cancer alliance strategic intelligence plan alongside ICB, reduce, reduce, 25/26.	Reduce	Reduce	Anthony Middleton	2025/26	On Track

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board				
Source	Planned Date /Frequency	Date/s provided	Assurance Rating	
Performance reporting to Quality & Performance Committee & ICB Board	Monthly & bi-monthly	Monthly & bi-monthly	Acceptable	

Programme delivery reporting to Strategy & Transformation Committee, ICB Board	Bi-monthly	Bi-monthly	
Children and Young People's Elective Wait Recovery: accelerated delivery proposal	-	26/9/24	
Gaps in assurance			
<p>All Trusts were committed to eliminate waits over 65 weeks by September (extended to December 2024) per 24-25 operational plans, however it is noted that certain specialties are particularly pressured, including ENT, T&O, Plastics and Gynaecology, and that there are a small number of Trusts who are going to be unable to achieve this due to levels of capacity issues, resources and operational pressures. Each of the "breach" patients are validated and tracked on a daily and weekly basis, and we are looking at additional opportunities for mutual aid and shared support between the trusts.</p>			
Actions planned	Owner	Timescale	Rating
Weekly patient tracking list meetings all trusts	Anthony Middleton (via CMAST)	2024-25	On Track
C&M Elective Recovery Mutual Aid Team broker mutual aid	Anthony Middleton (via CMAST)	2024-25	On Track

ID No: P4					Risk Title: Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience				
Risk Description (max 100 words)		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.							
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				13/12/24				15/04/25	

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	3	2	2	2		2	31/3/25	The ICB has a low appetite for risk that impacts on patient safety. Our longer-term aspiration remains to reduce further to a moderate (1x5=5) level.
Impact	5	5	5	5		5		
Risk Score	15	10	10	10		10		
Rationale for score & progress in quarter (max 300 words)	There is potential for multiple deaths, permanent injuries or irreversible health effects, or harm to more than 50 people, totally unacceptable quality of clinical care, and gross failure to meet national standards (impact 5). Current controls are effective in reducing the likelihood, to unlikely (2). Good progress has been made in establishing the quality oversight framework providing a firm foundation for identifying emerging concerns and appropriate intervention. The increased focus on the resources available and our need to increase our productivity in 2024-25 makes it increasingly important to mitigate any potential impact to the quality and safety of commissioned services, and as a result it is anticipated that progress in further reducing this risk will be limited during the current financial year.							

Current Key Controls					Rating
Policies	Clinical Quality Strategy, National Quality Board guidance on risk management and escalation, Safeguarding legislation and policy alignment, Patient Safety policy alignment, including Patient Safety Incident Response Framework				A
Processes	System Quality Group, Emerging Concerns Group, Clinical Effectiveness Group, Multi- agency safeguarding boards/partnerships, Infection Prevention Control/Anti-Microbial Resistance Board, Place based quality partnership groups & serious incident panels, Quality Assurance Visits, Rapid Quality Reviews, Independent Investigations & other reviews and responses to national enquiries and investigations. System Wide Clinical Risk and Consensus Group created (Winter Safety). Development of Quality Statements to support 2025/26 Commissioning Intentions.				A
Plans	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 standardised C&M quality schedule, Service specifications, Safeguarding commissioning standards				G
Reporting	System Oversight Board, Quality & Performance Committee ICB Board, National quality reporting				G
Gaps in control					
Need to ensure NHS Impact & PSIRF are embedded and extended Development of data and intelligence platforms to identify and triangulate quality concerns / failures.					
Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Closedown Serious Incident Framework	Reduce	Maintain	Richard Crockford	31/03/25	On Track
Continuous review and alignment of quality reporting requirements	Reduce	Maintain	Chris Douglas	2024-25	On Track
Embedding NHS Impact approach	Reduce	Maintain	Fiona Lemmens	2024-25	On Track
Extending and embedding PSIRF	Reduce	Maintain	Richard Crockford	2024-25	On Track
Continue to develop BI capability to support intelligence led approach	Reduce	Maintain	Becky Williams	2024-25	On Track

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	Planned Date /Frequency	Date/s provided	Assurance Rating
Quality reporting to Quality & Performance Committee & ICB Board	Monthly	30/5/24, 25/7/24, 26/9/24, 30/11/24	Acceptable
Executive Director of Nursing & Care report to ICB	Bi-monthly	30/5/24, 25/7/24, 26/9/24, 30/11/24	
Regional quality group reporting	Bi-monthly		
Gaps in assurance			
Work to strengthen quality, safety and experience reporting through intelligence led approach			
Actions planned	Owner	Timescale	Rating
Continue to develop ability to be intelligence led	Chris Douglas / Rowen Pritchard Jones	2024-25	On Track
Strengthen approach to the use of patient experience insight and feedback to ensure the early identification of negative impact on patient experience	Kerry Lloyd	2024-25	On Track

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.				
Risk Description (max 100 words)		The wider urgent and emergency care system, spanning all sectors, 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 delayed discharges and longer stays, results in reduced flow from emergency departments, which in turn impacts waiting times in ED and ambulance response times. Such delays may result in patient harm and poor patient experience, and increased health inequalities.							
Senior Responsible Lead			Operational Lead			Directorate		Responsible Committee	
Anthony Middleton			Claire Sanders			Finance		ICB Executive	
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				11/12/24			15/04/25		

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	4	4	4		4	31/3/25	The ICB has a low tolerance for risks impacting patient safety and the aim is to reduce to a moderate/low level acknowledging that this will take 2-3 years to achieve.
Impact	5	5	5	5		5		
Risk Score	25	20	20	20		20		
Rationale for score & progress in quarter (max 300 words)	There is potential for multiple deaths, permanent injuries or irreversible health effects, or harm to more than 50 people, totally unacceptable quality of clinical care, and gross failure to meet national standards (impact 5). Current controls are effective in reducing the likelihood, but this is still likely (4). Urgent Care Recovery Programmes in 5 areas are focused on the key objective of eliminating corridor care in 24-25, as well as reducing the number of hospital attendances and admissions and improving discharge pathways and processes. The planned actions are currently on track, but as a result of current demand levels, it is not now anticipated that a reduction in the score will be achieved by year-end and the target score has been increased from 16 to 20.							

Current Key Controls					Rating
Policies	NHS Delivery plan for recovering urgent and emergency care services. Winter letter. SCC Review of Standards. Revised OPEL frameworks (Acute, Community, Mental Health and NHS 111)				G
Processes	System Coordination Centre, System wide operational planning, NHS Oversight Framework.				A
Plans	UEC Recovery Programme at scale workstreams and UEC Recovery plan of each of the 5 localities , C&M Operational Plan.				A
Contracts	NHS Standard Contract				G
Reporting	UEC Recovery and improvement Group, Strategy & Transformation Committee, Quality & Performance Committee, ICB Board				A
Gaps in control					
<p>Scale and frequency of future industrial action, GP collective action is unknown and likely to continue to impact on workforce capacity. Demand exceeds planned capacity levels in a range of sectors, and fuller understanding of demand and capacity across all sectors is required.</p> <p>Variation in processes C&M wide, e.g. application of patient choice, discharge processes.</p> <p>Revaluation of NEPTS is required as part of procurement process.</p>					
Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
At scale work stream admission avoidance	Reduce	Reduce	Tony Mayer	2024/25	On Track
At scale work stream ambulance improvement	Reduce	Reduce	Ian Moses	2024/25	On Track
At scale work stream acute discharge	Reduce	Reduce	Dan Grimes	2024/25	On Track
At scale work stream acute length of stay	Reduce	Reduce	Dan Grimes	2024/25	On Track
At scale work stream oversight resilience	Reduce	Reduce	Claire Sanders	2024/25	On Track
Urgent Care Improvement Programme – North Mersey	Reduce	Reduce	Leigh Thompson	2024/25	On Track
Tier 1 rapid improvement offer from National UEC/ECIST	Reduce	Reduce	Claire Sanders	31/12/24	On Track
Urgent Care Improvement Programme – Mersey and West Lancashire	Reduce	Reduce	Mark Palethorpe & Jenny Wood	2024/25	On Track

Urgent Care Improvement Programme – Cheshire	Reduce		Laura Marsh & Dan Grimes	2024/25	On Track
Urgent Care Improvement Programme – Warrington and Halton	Reduce		Carl Marsh	2024/25	On Track
Urgent Care Improvement Programme – Wirral	Reduce		Simon Banks	2024/25	On Track
UEC Clinical Risk and Consensus Group	Reduce		Rowan Pritchard-Jones	2024/25	On Track

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board				
Source	Planned Date /Frequency	Date/s provided	Assurance Rating	
UEC Recovery and Improvement Group	Monthly		Partial	
Recovery Programme delivery reporting to Recovery Committee & ICB Board	Monthly & bi-monthly	26/9/24		
Performance reporting to Quality & Performance Committee & ICB Board	Monthly & bi-monthly	30/5/24, 25/7/24, 26/9/24, 30/11/24		
Gaps in assurance				
Performance against the majority of urgent and emergency care measures is below target and England average.				
Actions planned	Owner	Timescale	Rating	
Urgent Care Improvement Programmes (as above)	Place Directors (as above)	2024/25	On Track	

ID No: P6					Risk Title: Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population				
Risk Description (max 100 words)		The COVID 19 pandemic generated significant backlogs due to reduced capacity to meet routine healthcare needs and people delaying seeking healthcare interventions, exacerbating existing inequalities in access to care and health outcomes. 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 and loss of stakeholder trust and confidence in the ICB.							
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				10/12/24			15/04/25		

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	4	3	3		3	31/03/25	The aim is to reduce to a moderate level of risk over the 2024-26 lifetime of access recovery / improvement plans.
Impact	4	4	4	4		4		
Risk Score	20	16	12	12		12		
Rationale for score & progress in quarter (max 300 words)	There is potential for significant reduction in health outcomes and/or life expectancy, significant increase in health inequality gap in deprived areas or socially excluded groups, adverse public reaction and significant impact on trust and confidence of stakeholders (impact 4). Current controls are effective in reducing the likelihood to possible (3). Ongoing delivery of Primary Care Access Recovery and Dental Improvement Plans is on target and currently achieving the target risk score of 12. From a Primary Medical perspective, the ongoing collective action by GP practices could drive up the score during the remainder of the year if patients are becoming impacted. There will be Place variation with the scoring. In addition, there is also a potential impact on community pharmacies due to the collective action which will also be monitored and could impact the scoreduring the remainder of the year. A new risk for the Collective Action has been drafted and discussed at the System Primary Care Committee who have oversight							

Current Key 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, National Dental Recovery Plan 2024				G
Processes	System and place level operational planning, performance monitoring, contract management, system oversight framework, place maturity / assurance framework.				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, Local Enhanced/Quality Contracts, Directed Enhanced Services – Primary Care Networks – Enhanced Access, GDS&PDS Contracts				G
Reporting	System Primary Care Committee, NW Regional Transformation Board, Quality & Performance Committee, ICB Board, HCP Board. Place Primary Care forums. Local Dental improvement plan delivery board				G
Gaps in control					
<p>Primary Care Strategic Framework version 2 to be completed & formally signed off.</p> <p>Ongoing successful delivery of the access recovery / improvement plans required over a 2-3 year period to close gap, specifically dental workforce and funding for primary medical baselines as reported by contractors.</p>					
Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Complete & secure approval to Primary Care Access Recovery Plan Y2			Chris Leese	30/11/24	Complete
Delivery of Access Recovery and Improvement Plans			Corporate & Place Primary Care Leads	2024-26	On Track
Delivery of Dental Improvement Plan 2024-26			Tom Knight	2024-26	On Track
Collective action EPRR process in place			EPRR Team/Chris Leese	2024-26	On Track

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	Planned Date /Frequency	Date/s provided	Committee Rating
Reporting on delivery to System Primary Care Committee & ICB Board	Quarterly	18/4/24	Acceptable
Performance Reporting to ICB Board	Bi-monthly	30/5/24, 25/7/24, 26/9/24	
ICB Board approval to Primary Care Access Recovery Plan Y2	November 24		
Gaps in assurance			
No Phase 2 of strategic framework			
Actions planned	Owner	Timescale	Rating
Secure approval to Primary Care Access Recovery Plan Y2	Chris Leese	30/11/24	Complete

ID No: P7 Risk Title: The Integrated Care System is unable to achieve its statutory financial duties				
Risk Description (max 100 words)	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, convergence adjustments for both core ICB allocations and specialised services and inflationary pressures anticipated in the short -medium term above funding settlements.			
Senior Responsible Lead	Operational Lead	Directorate		Responsible Committee
Mark Bakewell	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		13/12/24		16/02/25

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	4	4	4		4	31/03/25	The ICB is willing to pursue higher levels of risk while maintaining financial sustainability and efficient use of resources. The aim is to reduce to a moderate level over the 3-year financial plan.
Impact	5	5	5	4		4		
Risk Score	25	20	20	16		16		
Rationale for score & progress in quarter (max 300 words)	There is potential for a significant financial loss, and impact on trust and confidence of stakeholders (impact 4). The scale of the financial gap means that the likelihood is currently likely (4). The potential impact has reduced due to an improving financial position and it is proposed to amend year-end target score from 15 to 16 to reflect this. Planned actions to secure ICS wide agreement and NHSE approval to a Medium-Term Financial Strategy are in progress. The longer-term aim is to reduce to a moderate level over the lifetime of the medium-term financial strategy. A medium-term financial model has been shared with the Board which sets out the financial challenge and drivers of the deficit. The medium-term financial strategy will be developed as the associated transformation and commissioning strategies are progressed.							

Current Key Controls		Rating
Policies	Standing Financial Instructions, Scheme of Reservation & Delegation, Delegation Agreements (ICB / Place), Financial Policies	G
Processes	Financial planning	G
Plans	ICS Financial Plan 2024/25, Medium Term Financial Strategy	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

Medium Term Financial Strategy including Recovery Plan to be agreed.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Conclude 24-25 contracts	Reduce	Reduce	Claire Wilson	31/07/24	Complete
Develop Medium Term Financial Strategy including Financial Recovery Plan	Reduce	Reduce	Mark Bakewell	30/09/24	Problematic

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board

Source	Planned Date /Frequency	Date/s provided	Committee Rating
ICB Board approval of Medium-Term Financial Strategy	September 24		Partial
System Financial Report to ICB Board	Bi-monthly	25/7/24, 26/9/24, 30/11/24	
NHSE ICB Assessment	Annual (July)		

Gaps in assurance

ICS Medium Term Financial Strategy including Recovery Plan yet to be agreed

Actions planned	Owner	Timescale	Rating
Secure approval to Medium Term Financial Strategy	Mark Bakewell	30/09/24	Problematic

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				
Risk Description (max 100 words)		There are significant service sustainability challenges across the Cheshire and Merseyside system, including significant clinical risk and challenges identified by the Liverpool Clinical Services Review, and Trusts at SOF3, and a number of fragile hospital and other services across C&M. 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.							
Senior Responsible Lead			Operational Lead			Directorate		Responsible Committee	
Rowan Pritchard Jones			Fiona Lemmens/Carole Hill/ Mark Wilkinson			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				31/12/24				15/04/25	

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	4	3	3	3		3	31/03/25	The ICB has a low appetite for risk that impacts on patient outcomes. Our longer-term ambition is to moderate to (2x3=6) level of risk but will only be achievable over 2-3 years.
Impact	4	4	4	4		4		
Risk Score	16	12	12	12		12		
Rationale for score & progress in quarter (max 300 words)	<p>There is potential for major effect on quality of clinical care and non-compliance with national standards posing significant risk to patients, and significant impact on trust and confidence of stakeholders (impact 4). Current controls are maintaining the likelihood at possible (3). Strategic transformation programmes have been established to address service sustainability issues and work will continue to develop case for change and consultation proposals during 2024-25 but are not expected to be complete or impact on the risk level until 2025-26 and beyond. Progress has been made on key programs over the last quarter:</p> <ul style="list-style-type: none"> Shaping Care Together (SCT) case for change published and SCT programme in formal stage of public engagement in September and October 2024. – Complete 							

	<ul style="list-style-type: none"> • C&M Continuous Improvement Programme Steering Group and Cheshire and Merseyside Improvement Network established, and Delivery plan developed with a focus on supporting the ICB recovery programmes. • Women’s services in Liverpool programme case for change approved by ICB board and formal public engagement started on 15th October. In parallel work will begin on the design phase and development of a clinical model at a Clinical Reference group meeting in December 2024. A Lived Experience Panel has been established to support the programme. • Liverpool Clinical Services Review - Liverpool University Hospitals Foundation Trust and Liverpool Women’s FT come together as University Hospitals of Liverpool Group from 1 November. This will streamline decision-making and develop further collaboration opportunities in terms of service quality, access, workforce capacity and finance. Plans for other acute and specialist trusts to join a group structure, retaining their status as separate Trusts, are in development. • C&M CMAST clinical pathways programme - Cardiology options appraisal workshops established to develop plans for optimising cath lab provision across C&M in order to address poor performance and outcomes in Acute Coronary Syndrome (ACS) • initial stages of the options appraisal commenced including workshops on agreeing hurdle criteria and evaluation criteria • TOR for the establishment of a Joint committee between Lancs and south Cumbria ICB and C&M ICB agreed at both ICB public board meetings
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Current Key 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 and NHS Impact programme, Liverpool Place provider collaboration on urgent care pathways, CMAST Clinical Pathways Programme, Shaping Care Together Programme in Sefton Place, 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 Strategy & Transformation Committee, ICB Board	A
Gaps in control		
Progression through programme plans including where appropriate business case development, consultation and approval of key strategic transformation programmes is required to improve controls.		

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Continuous Improvement Approach	Maintain	Maintain	Fiona Lemmens	2024-25	On Track
Oversight of Shaping Care Together Programme delivery and milestones	Maintain	Maintain	Deb Butcher, Fiona Lemmens, Clare Watson	2024-25	On Track
Oversight of ECT Sustainable Hospitals Programme delivery and milestones	Maintain	Maintain	Mark Wilkinson, Fiona Lemmens, Clare Watson	2024-25	On Track
Oversight of Liverpool Clinical Services Review Programme delivery and milestones	Maintain	Maintain	Mark Bakewell	2024-25	On Track
Oversight of Womens Services in Liverpool Programme delivery and milestones	Maintain	Maintain	Fiona Lemmens, Chris Douglas	2024-25	On Track
Oversight of CMAST programmes	Maintain	Maintain	Fiona Lemmens	2024-25	On Track
Commence stage 2 of the EIA process	Maintain	Maintain		2024-25	On Track
Establish a joint HOSC with local authority leads	Maintain	Maintain		2024-25	On Track
Commenced drafting the Pre consultation Business Case	Maintain	Maintain		2024-25	On Track

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board				
Source	Planned Date /Frequency	Date/s provided	Assurance Rating	
Continuous Improvement updates to ICB Executives Committee	As required		Partial Assurance	
Shaping Care Together Programme Board updates to Strategy & Transformation Committee	Bi-monthly	Board – 25/7/24		
ECT Sustainable Hospitals Programme Board updates to Strategy & Transformation Committee	Quarterly			
LCSR Programme updates to One Liverpool Board and Strategy & Transformation Committee	TBC			
Womens Services in Liverpool Programme updates to ICB Women’s Services Committee	Quarterly	3/7/24 & Board – 9/10/24		

Recovery Programme delivery reporting to Recovery Committee & ICB Board	Fortnightly and Month Bi-Monthly	May – Sept (fortnightly) & Board – 30/5/24, 26/9/24	
CMAST programme updates to Strategy & Transformation Committee and Board	Quarterly	Board – 25/7/24	
Gaps in assurance			
Issues in relation to affordability and timescales will need to be addressed in pre consultation business cases for key programmes. The impact of the current ICB financial situation and associated planning processes on the various transformation processes remains uncertain.			
Actions planned	Owner	Timescale	Rating
Shaping Care Together (SCT) – conclude public engagement, analyse feedback and commence options appraisal process.	Deb Butcher, Fiona Lemmens, Clare Watson	2025-26 Q1	On Track
Women’s services in Liverpool programme - conclude public engagement, analyse feedback and commence options appraisal process	Fiona Lemmens, Chris Douglas	2025-26 Q2	On Track
All other programmes – oversight and assurance of milestone progress	Mark Bakewell, Mark Wilkinson, Fiona Lemmens, Clare Watson, Chris Douglas	2025-26 and beyond	On Track
Establishment of the Hospital group Model in Liverpool supports the internal work on short term patient safety improvement plans		2025-26 and beyond	On Track
Next meeting of Clinical Reference Group on 16.12.24 to commence the design of the optimum model of care and options appraisal process		2025-26 and beyond	On Track
Ongoing work on the short term patient safety improvement plans		2025-26 and beyond	On Track
Options appraisal for cath lad optimisation completed and report to be presented to CMAST Cardiac Alliance for consideration of next steps		2025-26 and beyond	On Track

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				
Risk Description (max 100 words)		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.							
Senior Responsible Lead			Operational Lead			Directorate		Responsible Committee	
Christine Samosa			Sarah Smith			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				23/12/24				15/04/24	

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	4	4	4	4		4	31/03/25	Our longer-term ambition is to moderate to a (2x3=6) level of risk but will only be achievable over 2-3 years due to resource allocation and capacity.
Impact	4	4	4	4		4		
Risk Score	16	16	16	16		16		
Rationale for score & progress in quarter (max 300 words)	There is potential for a major effect on quality of clinical care and significant financial loss (impact 4). Current controls are maintaining the likelihood at likely (4). Workforce Recovery Programme, supporting the implementation of the C&M Workforce Plan in 2024-25, is focused on identifying opportunities to optimise our resources to support a reduction in workforce costs whilst not compromising quality of care and the patient experience. Financial constraints have limited ability to increase workforce planning capacity but realignment of existing Peoples Team resources will enable a more limited work programme in the short term. Due to resource constraints, it is not now anticipated that a reduction in likelihood to possible (3) will be achieved by year-end and the target score has been increased to 16, with further reductions over a 2-3 year period dependent on resources.							

Current Key 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, NHSE/HEI supply data				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					
<p>Financial constraints have limited / deferred investment in workforce development capacity While manual System Workforce dashboard has been developed, need still exists for broader automated options. Limited maturity of collaborative working at system level Inconsistent workforce planning process/methodology across the system Insufficient links to educational institutions and local authorities Technology and inconsistent use of workforce systems across the region (ESR, ERoster, TRAC, NHS jobs, OH system)</p>					
Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Develop and enhance workforce planning capabilities across the system	Reduce	Maintain	Emma Hood	30/09/24	Complete
Scaling of Peoples Services	Reduce	Maintain	Sarah Smith	Review Apr 25	On Track
Plans to further develop and enhance workforce planning capabilities across the system as resources and capacity allow	TBC	TBC	TBC	2025-26	TBC

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	Planned Date /Frequency	Date/s provided	Assurance Rating
Integrated Quality & Performance Reports to ICB Board	Bi-monthly	30/5/24, 25/7/24, 26/9/24, 28/11/24	Partial Assurance
System workforce reporting to People Board	Quarterly		
NHS Equality Diversity and Inclusion Improvement Plan updates	Quarterly		
WRES & WDES reporting	Annual		
CQC Well Led review	Annual		
Gaps in assurance			
CQC approach to assessing integrated care systems is still evolving.			
Actions planned	Owner	Timescale	Rating
Respond to CQC framework	Clare Watson	2024/25	On Track

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				
Risk Description (max 100 words)		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.							
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			23/12/24				15/04/25		

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	4	3	3	3		3	Achieved	Interim target score achieved based on what is feasible for 2024/25. Our longer-term aim is to limit to a moderate level of risk, but this is unlikely before 2025/26.
Impact	4	3	3	3		3		
Risk Score	16	9	9	9		9		
Rationale for score & progress in quarter (max 300 words)	The current national and local quality, safety, performance and financial pressures during the post COVID recovery period gives rise to potential for significant reduction in health outcomes and/or life expectancy and significant increase in health inequality gap in deprived areas or socially excluded groups, criticism or intervention by NHSE and significant impact on trust and confidence of stakeholders (impact 4). This is mitigated by a refreshed Joint Forward Plan which includes a focus on urgent care and financial recovery during 24/25 which also need to reflect impacts on Core20+5 populations and our strategic ambitions. A revised HCP Strategy has been approved which aligns the HCP to the All Together Fairer plan to address health inequalities. In support of this a delivery plan has been developed together with a plan for investment into health inequalities which was presented to the Health and Care Partnership in July 2024 with a focus on smoking, healthy weight and housing, building on previous commitments, for example children and young people schemes. It is recognised							

that in the short term the level of resources available for this wider focus on longer term population health investments is constrained and may limit further progress in reducing this risk during the current financial year.

Current Key Controls					Rating
Policies	Constitution & membership of ICB Board & HCP, Public Engagement / Empowerment Framework, Prioritisation Framework.				G
Processes	Strategic planning, communication & engagement, programme & project management, culture & organisational development, Provider Collaboratives, C&M and sub-regional networks				G
Plans	HCP Strategy 2024-29, Joint 5-year Forward Plan 2024-29, Joint Health & Wellbeing Strategies x 9 places, Operational Plan, Communications & Engagement Plan, Provider Collaborative Business Plans, Financial Plan.				A
Contracts	MOU with NHSE for system oversight is in development				A
Reporting	C&M HCP Partnership Board, Place-based partnership boards & H&WB Boards, ICB Board				G
Gaps in control					
ICB operating model under review – timescale deferred in line with NHSE operating model review					
Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Refocus HCP Strategy 2024-2029 aligned to 'All Together Fairer'	Maintain	Maintain	Neil Evans & Ian Ashworth	30/08/24	Complete
Complete JFP 2024-29 (<i>delayed Board approval until post General Election</i>)	Maintain	Maintain	Neil Evans	31/07/24	Complete
Develop an update to propose a refreshed ICB operating model	Maintain	Maintain	Clare Watson	30/01/25	On Track
Identify ICB health inequalities funding that will be overseen by the HCP Committee to support delivery of Marmot the C&M All Together Fairer strategy and ambitions. To be presented to July HCP Meeting	Maintain	Maintain	Ian Ashworth	31/07/24	Complete

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	Planned Date /Frequency	Date/s provided	Assurance Rating
Approval of updated HCP Strategy (To be approved by HCP – August) & Joint Forward Plan 2024-29 (ICB Board - July)	July 2024	Board 25/7/24 & 26/9/24 HCP 1/10/24	Acceptable Assurance
Reporting on progress of delivery plans during 2024-25 (ICB Board and delegated Board Committee)	In line with delivery dates in plan		
Joint Overview & Scrutiny of HCP Strategy and Joint Forward Plan	As required		
NHSE Systems Oversight Framework	Quarterly Review with NHS England		
Gaps in assurance			
JFP requires annual refresh and needs to reflect both short and longer term (five year) description of ICB priorities.			
Actions planned	Owner	Timescale	Rating
Seek approval to updated HCP Strategy and JFP	Clare Watson	31/08/24	Complete
Development of ICB Integrated Business Plan to describe delivery of Joint Forward Plan and ICB Corporate, Operational and Financial Planning priorities	Neil Evans	31/08/24	Complete
Development of MOU with NHS England in relation to system oversight operating model	Clare Watson/Anthony Middleton	31/08/24	Complete

ID No: P11					Risk Title: The ICB is unable to address inadequacies in the digital infrastructure and related resources leading to disruption of key clinical systems and the delivery of high quality, safe and effective health and care services across Cheshire and Merseyside.				
Risk Description (max 100 words)		The ICB is responsible for leading ICS-wide cyber security. C&M is a complex system including the ICB, all 16 NHS providers, 349 GP practices and other related health and care services. Risks may arise from a Cyber security attack (either direct to one or more organisations or to one of their suppliers), lack of investment in resilient infrastructure and / or lack of appropriately skilled staffing. This could lead to possible financial and / or data loss, disruption to the delivery of patient care and/or damage to the reputation of one or more organisations in Cheshire and Merseyside.							
Senior Responsible Lead		Operational Lead			Directorate			Responsible Committee	
Rowan Pritchard-Jones		John Llewelyn			Medical			Strategy & Transformation	
Strategic Objective				Function		Risk Proximity		Risk Type	Risk Response
Tackling Health Inequality, Improving Outcomes and Access to Services Enhancing quality, productivity and value for money				Transformation		B – within the financial year		Principal	Manage
Date Raised			Last Updated			Next Update Due			
27/6/24			23/12/24			15/04/25			

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	4	4	4		4	31/3/25	The ICB has a low tolerance for risks impacting patient safety. The aim is to moderate to a (2x8) over two years as resources and capacity allow.
Impact	4	4	4	4		4		
Risk Score	20	16	16	16		16		
Rationale for score & progress in quarter (max 300 words)	There is the potential for patient harm, major effect on quality of clinical care, significant financial loss, significant loss of trust and confidence of stakeholders and adverse national media (impact 4). Current controls are sufficient to reduce the likelihood to likely (4). The possibility of a cyber-attack cannot be completely removed, and a residual risk will remain, but the implementation of the 5-Year Cheshire and Merseyside Cyber Security Strategy aims to reduce likelihood to unlikely (2) over the lifetime of the strategy. It is anticipated that limited investments possible in 2024-25 will maintain the risk at the current level. In year funding secured through national cyber resilience fund and that will fund the delivery of priorities in the programme. New programme manager appointed for the Cyber Strategy delivery. We anticipate a further round of funding next year and this year's programme will build the business case to support securing further funding. Issues in relation to cyber security							

	manager vacancy but this is being mitigated through support from our IT providers. Anticipate this risk level will be maintained for the remainder of the year but controls should reduce likelihood but is always subject to new threats arising.
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Current Key Controls		Rating
Policies	IT Security Policy (individual IT Service providers and organisations); IT Umbrella Policy, NHS England's CareCERT process, National Cyber security policy for England, What Good Looks Like success criteria, technical & data architecture standards, IT policies, information governance policies.	A
Processes	Cyber security systems & processes, Security audits & penetration tests, Digital maturity assessment, DSPT assessment & submissions, Cyber Associates Network, ICB monitoring of system wide cyber security standards. Clear incident management and support in major incidents agreed with ICB providers	A
Plans	ICS Cyber Security Strategy, Digital and Data Strategy 2022-2025, Investment (280k) & delivery plan in 2024/25, Cyber incident / Business continuity plan. National funding £620k revenue & £640k capital	A
Contracts	Cyber security monitoring tools inc. IT Health and Cynerio, IT provider contracts, data sharing agreements	A
Reporting	Digital Services Delivery Board (ICB infrastructure only), Digital Transformation & Clinical Improvement Assurance Board, Strategy & Transformation Committee	A

Gaps in control

ICS / ICB Capacity and investment to respond to continuously evolving threat.
 Gaps in ICB cyber leadership (Head of Cyber Security) and out of hours response capacity.
 Lack of organisational & system level monitoring and reporting of standards, compliance & risks.
 Further work required to raise awareness and understanding of cyber security at Board level & for all staff.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Cyber Security training for ICB Board	Reduce	Maintain	RPJ / JL	TBC	On Track
Further desktop Cyber exercise	Reduce	Maintain	JL / SP / MIAA	21/11/24	Complete
Benchmarking BAF/digital/cyber risks and associated processes across all healthcare organisations in Cheshire and Merseyside	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Develop a process for the transparent governance of provider level risks	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Define clear incident management and support in major incidents with ICB providers	Maintain	Reduce	CTO	30/09/24	Complete
Scope options and define requirements for Cyber security delivery model	Reduce	Maintain	JL / SP / MIAA	31/12/24	On Track

Explore opportunities to improve collaboration and sharing of Cyber resource across the Cheshire and Merseyside system	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Investigate and conclude upon the need for third party incident response capacity creating a business case for investment if deemed appropriate.	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Explore opportunity to standardize cyber tooling across C&M and procure at scale	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Analyse & map across C&M organisations, critical service/supply chain security assurances and gaps. Identify significant exposure points and report with recommended actions	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Work with ICB procurement & IG to create standard security and assurance procurement & contracts requirements & share across all organisations within the ICS.	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Undertake a skills survey across Digital teams within the ICS, analysing data to identify gaps in organisations and across the footprint and build out a training needs assessment based upon the outcomes.	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
DSPT becomes aligned to Cyber assessment framework in 24/25	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board				
Source	Planned Date /Frequency	Date/s provided	Committee Rating	
Cyber dashboard reporting to Digital Services Delivery Board / S&T Committee / Board	Quarterly (from Sept 24)		Partial	
S&T Committee and Board approval of ICS Cyber Security Strategy	March 2024	28/03/24		
Penetration testing – IT Providers and Trusts	March 2025 Annual			
Cyber Essentials accreditation – IT Providers and Trusts	Annual			
MIAA audit of DSPT in line with the mandated scope set out in the DSPT Independent Assessment Guide reported to Audit Committee	Annual	25/06/24		
2024-25 delivery plan progress reports	September 2024 Quarterly			
Approval of delivery plans for future years.	April 2025 Annual			

Gaps in assurance

No oversight of compliance with cyber security standards at organisation and system level across C&M
Funded delivery plans beyond 2024-25 yet to be established

Actions planned	Owner	Timescale	Rating
Develop cyber dashboard to provide oversight of compliance with key Cyber standards at organisation level	JL / SP / MIAA	31/03/25	On Track
Formalise Cyber risk reporting to the Board	JL / SP / MIAA	31/03/25	On Track
Review provider SLA's and existing Cyber investment to realign to requirements in the Cyber strategy.	JL	31/03/25	On Track

Meeting of the Board of NHS Cheshire and Merseyside

30 January 2025

ICB Corporate Risk Register – Quarter Three

Agenda Item No: ICB/01/25/21

Responsible Director: Clare Watson
Assistant Chief Executive

Corporate Risk Register – Quarter Three

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 15+.
- 2.2 There are currently 15 risks on the CRR at appendix one, including 4 critical risks and 11 extreme risks. The most significant risks are:
- 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 critical (20).
 - QU05 - Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm, currently rated as critical (20).
 - WSC6 - If patient safety, quality risks and clinical issues in the current women's services model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely, currently rated as critical (20).
 - PF1 - Common risk across places in relation to urgent care flow, including 'no criteria to reside', with a potential impact on safety and quality of care, currently rated as critical (20).
- 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 Since the November report:
- Four risks reported in November as in the pipeline: QU04, PF1, HPDAF2 and WiPDAF2, have been agreed for escalation by the Quality and Performance Committee.
 - QU15 - NWAS have stated that they may be unable to manage a high volume of mental health calls leading to a patient safety risk if calls not managed in a timely manner, currently rated as extreme (16) has yet to be considered by the Quality and Performance Committee and remains in the pipeline.
 - QU05 - Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm has increased from extreme (16) to critical (20).
 - There has been movement in the risk scores for some places as indicated in appendix two.

2.5 Two further quality and performance risks have been identified for escalation by specific places, which potentially also apply across other places. These are listed below and will be assessed by each place and subject to review and agreement by the Quality and Performance Committee.

- CEOps1 (Cheshire East) – Current investment levels within CE Place preventing delivery of the C&M standardised contract proposal for Talking Therapies contracts, leading to failure to perform against Access, Waiting time and Recovery Rate targets, leading to poor patient experience and potential harm, currently rated as extreme (15).
- WiP006 (Wirral) – Risk that the high prevalence of C Difficile infections in the Wirral system impacts on the quality of patient care and exacerbates operational pressures, currently rated as extreme (16).

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 15+.
- 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 The Corporate Risk Register has been compiled from current Committee and Directorate Risk Registers and provides an update on the report presented to the Board in November 2024.

6. [Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities](#)

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

- 6.1 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.

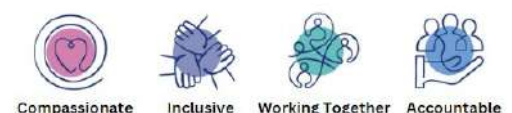
7. [Link to achieving the objectives of the Annual Delivery Plan](#)

- 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 15 risks on the CRR, including 4 critical risks and 11 extreme 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 **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 critical (20). Actions planned to increase control have been completed or are now established as on-going control measures. The impact continues to be monitored but the data is not yet available to confirm that the control measures are effective and as a result the Quality and Performance Committee are currently unable to support a reduction in score.

9.1.2 **QU05 - Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm**, currently rated as critical (20). The mitigation strategy includes a range of place level service and pathway improvement programmes in collaboration with partners, supported by the ICB at scale priority workstream.

9.1.3 **WSC6 – In relation to women’s services, if patient safety, quality risks and clinical issues in the current women’s services model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely**, currently rated as critical (20). Consideration was given to a reduction to 15 but following discussion it was confirmed it remains at 20. Current controls include oversight by LMNS and local CQPGs and the Patient Safety Incidence Response Framework. Key further action is the clinical design work for medium and long term in the programme plan.

9.1.4 **PF1 - Common risk across places in relation to urgent care flow, including ‘no criteria to reside’, with a potential impact on safety and quality of care**, currently rated as critical (20). Current controls include the ICB System Coordination Centre, performance and contract monitoring, and recovery plans. Key further actions include the implementation of the UEC Recovery Programme and Place Improvement Plans.

9.1.5 **PC1 – Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & 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.

- 9.1.6 **PC8 - Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services**, currently rated as extreme (15). This is being managed through place and ICB level monitoring, reporting and escalation and the ICB EPRR incident response process.
- 9.1.7 **WSC3 - Failure to secure the required financial resources for the transformation of women’s hospital services in Liverpool, combined with revenue implications, will negatively impact on the successful delivery of proposals**, currently rated as extreme (16). The C&M system is already financially challenged and therefore the risk score reflects that new expenditure and investment may not be possible in the current financial climate; this is as much about the wider availability of public sector capital as the C&M situation. A Finance and Estates Group is due to be established in January 2025 (as part of the emerging Programme governance and reporting arrangements). Further actions include baseline mapping to support the design phase and finance and estates modelling to support the options development – the latter action has a longer-term timescale of January – June 2025.
- 9.1.8 **14DR - There is a risk of the ICB’s critical information systems suffering a failure due to a cyber security attack leading to possible financial / data loss, disruption to services and patient care and/or damage to the reputation of the organisation**, currently rated as extreme (16). Current controls include a range of policies, cyber security software systems and associated processes to detect and prevent potential attacks. Further planned actions include delivery of the system wide Cyber Security Strategy, improvements to supplier management and continued training and awareness raising.
- 9.1.9 **WSC4 - If the programme is unable to deliver an agreed a model of care, women’s hospital services in Liverpool may not be able to meet clinical service specifications and could become clinically unsustainable leading to a loss of services; this could lead to further negative impacts on other providers across C&M and the north-west region**, currently rated as extreme (15). A ‘Clinical Leaders Group (CLG)’ has been established to support the programme board. The CLG is leading the model of care work on behalf of Programme Board, with Specialised Commissioning and Clinical Network Leads also involved in the design work. Capital and revenue implications of the future model of care, interim model of care and counterfactual case are to be formulated by the Finance and Estates Group from January 2025.
- 9.1.10 **T2 - Impact on health outcomes and inequalities through limited Access to Specialist Weight Management Services across Cheshire and Merseyside and litigation in non-compliance with NICE Technology Appraisals in relation to GLP1 Weight Loss Drugs**, currently rated as extreme (16). This is currently being mitigated through interim measures to delay withdrawal of services in Liverpool, St Helens

and Halton. Further actions include an interim ICB commissioning policy for referral to digital providers and planning to adopt forthcoming NHSE and NICE guidance.

- 9.1.11 **QU04 - Delays in recruitment to fill gaps in the Safeguarding Service may lead to failure to provide statutory functions and meet core standards resulting in patient harm**, currently rated as extreme (15). Current controls include working across place footprints and prioritising statutory duties. Further actions include the commencement of a talent pipeline / career path for Designated Nurses.
- 9.1.12 **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. Plans to address gaps in controls have progressed, with work on-going to establish reporting dashboards to support assurance and oversight. ICB Business Intelligence Team have developed Power BI tools to facilitate this work and are now reporting a progress update whereby the Quality Dashboard is ready to be tested and, if successful, rolled out.
- 9.1.13 **F8/9 - Common risk across places that as a result of increasing demands, inflationary pressures and restricted options / inability to deliver recurrent efficiency savings, there is a risk of significant overspends against the Place budget which may affect the ICB's ability to meet statutory financial duties**, current rating has reduced from critical (20) to extreme (16). Current controls include delegated budgets, budgetary control and expenditure approvals process, financial recovery programmes and efficiency schemes, and financial monitoring and reporting. Key further action is being taken to address cost pressures in relation to CHC and prescribing, and to develop longer-term financial plans delivering recurrent efficiencies.
- 9.1.14 **HPDAF2 / WiPDAF2 - Halton / Wirral health and care system is unable to meet the needs of children and young people with complex and/or additional needs leading to long term health issues, increased inequalities and demands on services**, both currently rated as extreme (16). Current controls include SEND strategies, policies and action plans, NHS and local authority contracts, and oversight by improvement and partnership boards. Key further actions comprise delivery of improvement actions in collaboration with local partners.

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.

9.3 A summary of the assurance ratings for each of the risks escalated to the CRR is provided below:

ID	Risk	Committee	Current Score (Q3)	Controls					Assurance Rating
				Policies	Processes	Plans	Contracts	Reporting	
PC1	Primary Care Workforce	SPCC	16	G	G	G	G	G	Acceptable
PC8	Collective Action	SPCC	16	G	G	G		G	Partial
WSC3	Women's Services investment	Women's	16	G	G	G	G	G	Partial
QU09	ECT SHMI	Q&P	20	G	G	G	A	G	Partial
14DR	Cyber attack	S&T	16	A	A	A	A	A	Partial
WSC4	Women's Services model of care	Women's	15		G	G		G	Partial
T2	Weight management	S&T	16	G	A	R	A	A	Partial
QU04	Safeguarding capacity	Q&P	15	G	A	G	G	G	Partial
QU05	Neurodevelopmental assessments	Q&P	20	A	G	A	G	A	Partial
QU08	Standards of care	Q&P	16	A	A	A	A	A	
WSC6	Women's Services safety and quality	Women's	20	G	G	G	G	G	Acceptable
F8/9	Place cost pressures / efficiencies	FIRC	16	G	A	A	A	G	Partial
PF1	Place NCTR / UEC	Q&P	20	G	A	A	G	A	Partial
HPDAF2	Halton CYP complex needs	Q&P	16	A	R	A	A	R	Partial
WiPDAF2	Wirral CYP complex needs	Q&P	16	G	A	A	G	G	Partial

9.4 Sources of assurance in relation to key controls are 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 financial risk F8, 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

- 12.1 Risks QU05, WSC3, WSC4, WSC6, WiPDAF2 and HPDAF2 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.
- 11.2 Risks QU09, QU08, QU15, T2, PC8, WiPDAF2 and HPDAF2 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.

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:** Place Risk Distribution
- Appendix Three:** Risk Summaries

Appendix One
Corporate Risk Register – January 2025

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 & Dental Services)	Primary Care	Clare Watson	16	16	12	9	A – Within 3 months
PC8	Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services.	Primary Care	Clare Watson	15	16	15	12	B – Within 12 months
Finance Directorate								
WSC3	Failure to secure the required financial resources for the transformation of women’s hospital services in Liverpool, combined with revenue implications, will negatively impact on the successful delivery of proposals.	Women's Services	Claire Wilson	16	16	16	8	C – Beyond 12 months
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 3 months
14DR	There is a risk of the ICB’s critical information systems suffering a failure due to a cyber security attack leading to possible financial / Data loss, disruption to services and patient care and/or damage to the reputation of the organisation	Strategy & Transformation Committee	John Llewellyn	16	16	16	12	A – Within 3 months

Risk ID	Risk Title	Committee	Senior Responsible Owner	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Previous Risk Score (LxI)	Target Score	Risk Proximity
WSC4	If the programme is unable to deliver an agreed a model of care, women's hospital services in Liverpool may not be able to meet clinical service specifications and could become clinically unsustainable leading to a loss of services; this could lead to further negative impacts on other providers across C&M and the north west region	Women's Services	Christine Douglas	15	15	15	10	C – Beyond 12 months
T2	Impact on health outcomes and inequalities through limited Access to Specialist Weight Management Services across Cheshire and Merseyside and litigation in non-compliance with NICE Technology Appraisals in relation to GLP1 Weight Loss Drugs	Strategy & Transformation	Fiona Lemmens	16	16	16	9	A – Within 3 months
Nursing and Care								
QU04	Delays in recruitment to fill gaps in the Safeguarding Service may lead to failure to provide statutory functions and meet core standards resulting in patient harm	Quality & Performance	Christine Douglas	20	16	15	8	A – Within 3 months
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	16	8	A – Within 3 months
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	16	10	A – Within 3 months
WSC6	If patient safety, quality risks and clinical issues in the current women's services model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely	Women's Services	Christine Douglas	20	20	20	8	A – Within 3 months

Risk ID	Risk Title	Committee	Senior Responsible Owner	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Previous Risk Score (LxI)	Target Score	Risk Proximity
Place Directorates								
F8/9	As a result of increasing demands, inflationary pressures and restricted options / inability to deliver recurrent efficiency savings, there is a risk of significant overspends against the Place budget which may affect the ICB's ability to meet statutory financial duties.	Finance, Investment & Our Resources	Place Directors	25	16	16	12	B – Within 12 months
PF1	Demand, capacity and flow challenges across the wider urgent and emergency care system, spanning primary care, community and mental health care and social care, resulting in high levels of NCTR patients could result in risk of patient harm and poor experience of care	Quality & Performance	Place Directors	25	20	20	15	A – Within 3 months
WiPDAF2	Wirral health and care system is unable to meet the needs of children and young people with complex and/or additional needs leading to long term health issues, increased inequalities and demands on services	Quality & Performance	Simon Banks	20	16	16	8	C – Beyond 12 months
HPDAF2	Halton health and care system is unable to meet the needs of children and young people with complex and/or additional needs leading to long term health issues, increased inequalities and demands on services	Quality & Performance	Anthony Leo	16	16	16	12	C – Beyond 12 months

Appendix Two
Place Risk Distribution – January 2025

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

Appendix Three
Risk Summaries

ID No: 1PC		Risk Title: Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & Dental Services)																								
		Likelihood	Impact	Risk Score	Trend																					
Initial Risk Score <i>[assess on 5x5 scale, this is the score before any controls are applied]</i>		3	3	9	<table border="1"> <caption>Trend Data</caption> <thead> <tr> <th>Period</th> <th>Current</th> <th>Target</th> </tr> </thead> <tbody> <tr> <td>23/24: EOY</td> <td>16</td> <td>9</td> </tr> <tr> <td>24/25: Q1</td> <td>16</td> <td>9</td> </tr> <tr> <td>24/25: Q2</td> <td>16</td> <td>9</td> </tr> <tr> <td>24/25: Q3</td> <td>12</td> <td>9</td> </tr> <tr> <td>24/25: Q4</td> <td>12</td> <td>9</td> </tr> </tbody> </table>				Period	Current	Target	23/24: EOY	16	9	24/25: Q1	16	9	24/25: Q2	16	9	24/25: Q3	12	9	24/25: Q4	12	9
Period	Current	Target																								
23/24: EOY	16	9																								
24/25: Q1	16	9																								
24/25: Q2	16	9																								
24/25: Q3	12	9																								
24/25: Q4	12	9																								
Current Risk Score		4	4	12 ↓																						
Risk Appetite/Target Risk Score		3	3	9																						
Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral																		
12 ↔	12 ↔	N/A	4 ↓	12 ↔	N/A	12 ↔ 12 ↔	N/A	9 ↔																		
Senior Responsible Lead		Operational Lead		Directorate		Responsible Committee																				
Associate Director of Primary Care (CL)/ Head of Primary Care (TK)		Place Primary Care Leads/ ICB PC Manager (JJ)/ Senior Commissioning Mgr (LD)		Assistant Chief Executive/ Place Primary Care Structures		System Primary Care Committee																				
Strategic Objective	Function	Risk Proximity		Risk Type		Risk Response																				
Improving Population Health & Healthcare	Quality, performance, transformation, commissioning.	A – within the next quarter		Corporate		Manage																				
Date Raised			Last Updated			Next Update Due																				
01/07/2022* <i>Legacy CCG Risk</i>			Oct 2024			Dec 2024																				
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). Previously a legacy CCG risk across all 9 CCGs; this has been further expanded to include similar pressures across Community Pharmacy and General Dental Service provision. This is a national issue (more than a risk) around contractual performance being reduced as GPs, dental practices and Pharmacies struggle to recruit suitably qualified and experienced staff. Workforce pressures are impacting on opening hours and access to services. Note individual examples of place-based practice resilience and operational concerns are captured on local place risk registers, but the combined issue across C&M is captured on the overall corporate ICB risk register so that there can be assurances in respect of the overall resilience and sustainability of primary care. This cross references with BAF risk P6 and People's Board risk around workforce sustainability.

At September 2024: Although Primary Care workforce remains challenged, across our nine places there is variation in the driving forces behind this risk e.g. some are related to workforce (GP turnover, succession planning etc), others are related to provision of estate e.g. to house the new ARRS roles. Overall controls and mitigations across the places are robust; although there remains an ongoing pressure in general across Community Pharmacy, Dental and General Practice, with a lack of key trained primary professional staff, in particular GPs, Pharmacists and Dentists (in the NHS family). Work continues alongside our primary care partners to respond to national asks/ targets and local demand/ pressures, and all places have robust local oversight & reporting arrangements in place. Urgent care process in place for dental treatment for vulnerable patients; and mitigating wider national issue relating to the dental services contract with some flexible arrangements and negotiation of financial values. Recommend to committee score is **reduced** to 12 (remaining a likely (4) likelihood, but reduced impact to moderate (3) – to reflect mitigations in place and business as usual management across 9 places, and central/ national support/steer.

General Practice: Overall positive uptake of ARRS across the nine places, helping bolster the primary care workforce with alternative roles; and as at September, salaried GPs have now been added to ARRS roles, with guidance released, due to take effect from 01/10.

Community Pharmacy: The reported numbers of total workforce have increased 4% from 2022 (using FTE); with the largest increase in trained medicines counter assistants (39%), pre-registration trainee pharmacy technicians (33%) and pharmacy delivery drivers (26%). The number of all pharmacists reported (as headcount) continues to be in the region of 27,000 (27,487). However, despite workforce numbers increasing, Community Pharmacy England has recently released a national report confirming financial pressures are putting community pharmacies at risk of closure, threatening patient care and access to services across England, with increased workload & demand on community pharmacies. Work is underway to scope the risks relating to this.

Dental: Still awaiting the results of the national dental survey in primary care which is due to be published by NHSE imminently. This survey is completed by practices and the data collected by NHSBA who then report to NHSE for publication.; however, ICB Workforce Steering Group monitors figures and can confirm 4 additional Dental Foundation Trainees (DFTs) have been allocated to dental practices across C&M. As part of the local Dental Improvement Plan providing urgent care and completion of treatment. National work is underway looking at how we incentivise our newly qualified dentists to stay once they complete their training. At a local level we have been encouraging the use

<p>of alternative roles – Dental Nurses, Therapists and Hygienists, and have seen steady growth in activity; although dental nurse uptake, nationally, remains quite low. Dental Improvement Plan has specific workforce focus.</p>		
Current Controls		Rating
Policies	<ul style="list-style-type: none"> National Stock takes 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/ Dental Improvement Action Plan Delivering Operational Resilience across the NHS Winter 2023 	G
Processes	<ul style="list-style-type: none"> System Primary Care Committee – escalation to/ from Managed operationally at place level through place governance (escalation to SPCC as needed). Working with National Team and DoH on workforce issues and support. Primary Care Workforce Steering Group reporting Access Improvement Plan Templates submission 20/10 highlighting what place actions are being undertaken 	G
Plans	<ul style="list-style-type: none"> 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 & Dental Foundation Trainee programme GP retention plan (submitted May 2023) ICB Access Recovery plan approved by ICB Board (October) 	G
Contracts	<ul style="list-style-type: none"> GMS PMS APMS GDS PDS Contracts updated Local Enhanced/Quality Contracts/ Directed Enhanced Services Community Pharmacy Contracts 	G
Reporting	<ul style="list-style-type: none"> 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 - Access Improvement Plan Templates submission Place reporting to System Primary Care Committee through reporting template already agreed noting a clearer risk principal escalation process is to be developed System Primary Care Committee reporting through to Northwest Regional Structures 	G

			<ul style="list-style-type: none"> Reporting to PSRC Committee and through community pharmacy commissioning Team 	
Gaps in control				
<ul style="list-style-type: none"> Reporting between People Board and SPCC to be developed Consistent single set of data to be reported to People Board/ SPCC 				
Actions planned		Owner	Timescale	Progress Update
Dental Improvement in place agreed and progressing		Tom Knight	Complete	Implementation slowed down due to financial impact. Dental ringfence removed nationally which has resulted in the implementation aspirations
Assurances				
Planned			Actual	Rating
Closing BI data gaps for Workforce (Ongoing)			Regular updates at SPCC on System Pressures	Significant
Dental Improvement Plan in place – however impact on workforce to be determined.			First meeting of PC workforce steering group held May 2023	
Salaried GP Guidance (ARRS role) due to take effect 01/10/24			Primary Care Access Recovery Improvement Plan approved by ICB Board in November	
			Review of Place risks to establish position/ scoring – SPCC risk summary updated to reflect distribution of risk across places and collaborative actions to mitigate	
Gaps in assurance				
<i>[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]</i>				
<ul style="list-style-type: none"> Some BI data gaps remain 				
Actions planned		Owner	Timescale	Progress Update
Working with National Team and DH on workforce issues and support.		CL/ TK/ JJ	Ongoing	
Working locally with LPCs and contractors to understand & quantify issues and where required managing risk via contractual compliance routes/ local arbitration processes.		CL/ TK/ JJ	Ongoing	
Tracking the C&M risk against national and regional closure rates for comparison.		CL/ TK/ JJ	Ongoing	

ID No: 8PC		Risk Title: Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services.					
		Likelihood	Impact	Risk Score	Trend		
Initial Risk Score <i>[assess on 5x5 scale, this is the score before any controls are applied]</i>		3	5	15			
Current Risk Score		3	5	15 ↔			
Target Risk Score		3	4	12			
Senior Responsible Lead		Operational Lead		Directorate		Responsible Committee	
System Level – Clare Watson, Assistant Chief Executive		Christopher Leese, Associate Director of Primary Care		Assistant Chief Executive/ Primary Care		System Primary Care Committee	
Strategic Objective	Function		Risk Proximity	Risk Type		Risk Response	
Enhancing Quality, Productivity and Value for Money	Primary Care/ Quality/ Performance		B – within this financial year	Corporate and Place		Manage/ Mitigate <i>(removal will depend on factors nationally)</i>	
Date Raised		Last Updated			Next Update Due		
June 2024		Oct 2024			Dec 2024		
Risk Description							
<p>Following the release of the national contract terms related to finance, there are national and local pressures from some GPs to take collective action in relation to concentrating only on delivering core essential services as per contractual agreements. This would impact on patient care and services to varying degrees depending on the services and scale of the action (e.g. whether localised or spread out across the system). The universality of the action isn't clear at present with responses and feedback being worked through. This may impact on other providers including secondary care and community pharmacists, as well as patients.</p> <p>September Update: Score remains 15 (possible (3) likelihood by a catastrophic (5) impact). There are a number of practices who have indicated that they will be taking a form of this action, and this is currently being managed at place level; with the EPRR team managing the total operational picture of the impact on the system and providing twice weekly escalation to NHSE of a summary of issues from places. EPRR team can provide further information as required. As at 30/09 there has been no formal notification of a serious system, or practice,</p>							

operational impact yet. This is being closely monitored and will be assessed over time. The ICB is in continuous dialogue with NHSE re: any national actions to mitigate this action.			
Linked Operational Risks	Sustainability of General Practice Workforce Place related risks		
Current Controls			Rating
Policies	Region have issued supporting documentation and template for system readiness and assessment		G
Processes	Escalation systems in place – place and corporate Escalation and reporting in place ICB to Region Informal temperature check-ins with Region ICB EPRR process in place ICB corporate meetings with all LMCS – regular agenda item		G
Plans	A regional temperature check/status template was completed for Region		G
Contracts			
Reporting	System Primary Care Committee regular update/Standing agenda item Place Primary Care Forums EPRR / System Control Centre Regional ICB Check-ins now in place		G
Gaps in control			
<ul style="list-style-type: none"> 24/25 Contract offer is a nationally-led process 			
Actions planned	Owner	Timescale	Progress Update
Further ICB / Regional Reporting	JG/CL	In progress	
Place/Corporate regular check ins – initially fortnightly primary care leads	CL	Ongoing	Places developing place-level risk as appropriate – some places have had practices indicate they will be taking some form of action; other places this is still in discussion.
Place individual actions/plans (see Place level risk/plans)	Place PC Leads	Ongoing	Place level risk reporting varies in maturity across the nine places – as above.
Assurances			
Planned		Actual	Rating
Inter ICB readiness Assurance – more formal EPRR type readiness		Considered but not in place at this stage depending on how things progress	Partial

Gaps in assurance				
As above				
Actions planned	Owner	Timescale	Progress Update	
Maintain continuous dialogue with NHSE re: national steer.	EPRR Team/ CL	Ongoing		

ID No: WSC 3	Failure to secure the required financial resources for the transformation of women’s hospital services in Liverpool will negatively impact on the successful delivery of proposals.
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	Likelihood	Impact	Risk Score	Trend
Initial Risk Score <i>[assess on 5x5 scale, this is the score before any controls are applied]</i>	4	4	16	
Current Risk Score	4	4	16	
Risk Appetite/Target Risk Score	2	4	8	

Senior Responsible Lead	Operational Lead	ICB Directorate	Responsible Committee
Claire Wilson	Frankie Morris / Jenny Hannon	Finance	Women’s Services Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Productivity and Value for Money	Finance	C – beyond 12 months	Principal	Manage

Date Raised	Last Updated	Next Update Due
17/01/2024	20/11/24	15/04/25

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]*

Failure to secure the required financial resources for the transformation of women’s hospital services in Liverpool will negatively impact on the successful delivery of proposals. The appraisal of options will consider relative capital costs / revenue implications and the deliverability of proposals in this context. It is likely that all proposals will require a level of capital funding. In addition, a dedicated programme budget is required that will include the budget for key programme roles and involvement activities.

Current Controls		Rating	
Policies	ICB SOs and SFIs	G	
Processes	Finance and estates group to be established; applications for national capital if available; programme budgeting	G	
Plans	C&M Joint Forward Plan 2023-2028; NHSE 3-year delivery plan for maternity plan (2023); Involvement activity plan(s)	G	
Contracts	N/A	G	
Reporting	Regular reports to the Programme Board, WSC, Provider Trust Boards (LWFT, LUHFT, AHCFT, CCCFT) and Liverpool Joint 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]			
C&M system is already financially challenged – any new expenditure and investments may not be possible in the current financial climate.			
Actions planned	Owner	Timescale	Progress Update
Agree programme budget / resourcing plan	CW / CP	Sept 24 - Complete	C&E budget and additional programme resources agreed.
Establish finance and estates group	CW / JH	Jan 25	To support options process.
Undertake baseline mapping to support design phase	CW / JH	From Jan 25	
Undertake finance and estates modelling to support options development	CW / JH	Jan - Jun 25	

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances				
Planned		Actual		Rating
Women's Services in Liverpool Programme updates to ICB Women's Services Committee		Women's Services Committee – 3/7/24 & ICB Board – 9/10/24		Partial Assurance
Independent financial / economic modelling may be required to support the development and assessment of options – to be considered as part of programme budgeting				
Gaps in assurance [areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]				
The programme is not yet at the point where investment needs can be quantified or funding secured				
		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
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		Likelihood	Impact	Risk Score	Trend			
Initial Risk Score <i>[assess on 5x5 scale, this is the score before any controls are applied]</i>		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
Medical Director - Rowan Pritchard-Jones	ADQSI – East Cheshire	Medical	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improve population health	Quality	A – within next quarter	Corporate	Manage

Raised	Updated	Next Update Due
2023	Nov-2024	Apr-2025

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]
<p>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.</p>

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; 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	G
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 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. SHMI dashboard in development with ICB BI and Trust BI support.	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. RQR SHMI Improvement Plan - developed and refined. Driver diagrams now in place	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]		
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.

Actions planned	Owner	Timescale	Progress Update
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 15 th December 2023. Completed- now had 2 SHMI quality improvement meetings. Next meeting April 2024
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. Update provided at SHMI quality improvement meeting on 23 rd Feb. Ward staff are actively engaged with quality improvement work.
Monthly data analysis/ scrutiny of report from C2Ai	John Hunter/ Rowan Pritchard-Jones	ongoing	Monthly reports are now being received, analysed and will inform the SHMI dashboard. Ongoing review monthly by Medical Director and John Hunter.

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.	A
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 is required until improvements are seen.

Actions planned	Owner	Timescale	Progress Update

ID No:14DR		Risk Title: There is a risk of the ICB's critical information systems suffering a failure due to a cyber security attack leading to possible financial / Data loss, disruption to services and patient care and/or damage to the reputation of the organisation		
	Likelihood	Impact	Risk Score	Trend
Inherent Risk Score <i>[assess on 5x5 scale, this is the score without any controls applied]</i>	4	4	16	
Current Risk Score	4	4	16	
Target Risk Score	3	4	12	

Senior Responsible Lead	Operational Lead	Directorate		Responsible Committee		
John Llewellyn	Cathy Fox	Medical		Strategy & Transformation		
Strategic Objective			Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequality, Improving Outcomes and Access to Services Enhancing quality, productivity and value for money			Digital	A – within 3 months	Corporate	Manage
Date Raised		Last Updated		Next Update Due 26/1/24		
26/1/24		23/12/24		15/04/25		

Risk Description (max 100 words)

The ICB is dependent on IT and information systems to deliver its statutory functions and strategic objectives. There is a significant threat of cyber-attack from a wide range of sources with NHS organisations being a potential target, and new types of threat emerging on a regular basis. This risk concerns the potential for a successful attack on the ICB's systems which could disrupt service delivery and patient care, and lead to data loss, financial loss and reputational damage.

Current Controls	Rating
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Policies	IT Security Policy (individual IT Service providers); IT Umbrella Policy, NHS England's CareCERT process, National Cyber security policy for England, What Good Looks Like success criteria, technical & data architecture standards, IT policies, information governance policies.	A
Processes	Cyber security systems & processes, Security audits & penetration tests, Digital maturity assessment, DSPT assessment & submissions, Cyber Associates Network, incident management	A
Plans	ICS Cyber Security Strategy, Digital and Data Strategy 2022-2025, Cyber incident / Business continuity plan. Local / national funding and investment benefiting ICB	A
Contracts	Cyber security monitoring tools inc. IT Health and Cynerio, IT provider contracts, data sharing agreements	A
Reporting	Digital Services Delivery Board, Digital Transformation & Clinical Improvement Assurance Board, Strategy & Transformation Committee	A
Gaps in control		
<p>ICB Capacity and investment to respond to continuously evolving threat. Gaps in ICB cyber leadership (Head of Cyber Security) and out of hours response capacity. Lack of organisational level monitoring and reporting of standards, compliance & risks. Further work required to raise awareness and understanding of cyber security at Board level & for all staff.</p>		

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Cyber Security training for ICB Board	Reduce	Maintain	RPJ / JL	TBC	On Track
Further desktop Cyber exercise	Reduce	Maintain	JL / SP / MIAA	21/11/24	Complete
Benchmarking BAF/digital/cyber risks and associated processes across all healthcare organisations in Cheshire and Merseyside	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Develop a process for the transparent governance of provider level risks	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Define clear incident management and support in major incidents with ICB providers	Maintain	Reduce	CTO	30/09/24	Complete
Scope options and define requirements for Cyber security delivery model	Reduce	Maintain	JL / SP / MIAA	31/12/24	On Track
Explore opportunities to improve collaboration and sharing of Cyber resource across the Cheshire and Merseyside system	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track

Investigate and conclude upon the need for third party incident response capacity creating a business case for investment if deemed appropriate.	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Explore opportunity to standardize cyber tooling across C&M and procure at scale	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Analyse & map across C&M organisations, critical service/supply chain security assurances and gaps. Identify significant exposure points and report with recommended actions	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Work with ICB procurement & IG to create standard security and assurance procurement & contracts requirements (including NHS/non NHS & right to audit) & share across all organisations within the ICS.	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Undertake a skills survey across Digital teams within the ICS, analysing data to identify gaps in organisations and across the footprint and build out a training needs assessment based upon the outcomes.	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
DSPT becomes aligned to Cyber assessment framework in 24/25	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board				
Source	Planned Date /Frequency	Date/s provided	Committee Rating	
Cyber dashboard reporting to Digital Services Delivery Board / S&T Committee / Board	Quarterly (from March 2025)		Partial	
S&T Committee and Board approval of ICS Cyber Security Strategy	March 2024	28/03/24		
Penetration testing – IT Providers and Trusts	March 2025 Annual			
Cyber Essentials accreditation – IT Providers and Trusts	Annual			
MIAA audit of DSPT in line with the mandated scope set out in the DSPT Independent Assessment Guide reported to Audit Committee	Annual	25/06/24		
2024-25 delivery plan progress reports	September 2024 Quarterly			
Approval of delivery plans for future years.	April 2025 Annual			

Gaps in assurance			
Funded Cyber Security Strategy delivery plans beyond 2024-25 yet to be established No oversight of compliance with cyber security standards at organisation and system level across C&M			
Actions planned	Owner	Timescale	Rating
Develop cyber dashboard to provide oversight of compliance with key Cyber standards at organisation level	JL / SP / MIAA	31/03/25	On Track
Formalise Cyber risk reporting to the Board	JL / SP / MIAA	31/03/25	On Track
Review provider SLA's and existing Cyber investment to realign to requirements in the Cyber strategy.	JL	31/03/25	On Track

ID No: WSC 4	If the programme is unable to deliver an agreed model of care, women’s hospital services in Liverpool may not be able to meet clinical service specifications and could become clinically unsustainable leading to a loss of services; this could lead to further negative impacts on other providers across C&M and the North West region.
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	Likelihood	Impact	Risk Score	Trend
Initial Risk Score <i>[assess on 5x5 scale, this is the score before any controls are applied]</i>	3	5	15	
Current Risk Score	3	5	15	
Risk Appetite/Target Risk Score	2	5	10	

Senior Responsible Leads	Operational Leads	Directorate	Responsible Committee
Chris Douglas / James Sumner	Mandish Dhanjal / Lynn Greenhalgh / Fiona Lemmens	Medical	Women’s Services Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequalities in access, outcomes and experience; Improving Population Health and Healthcare	Medical	C – beyond 12 months	Corporate	Manage

Date Raised	Last Updated	Next Update Due
17/01/2024	20/11/2024	15/04/25

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]*

Without an agreed clinical model of care that meets the required commissioning specifications, there is a risk that complex services requiring specialist multidisciplinary support may be de-commissioned or lost from Liverpool. For example LWHT already has to send pregnant women with complex cardiac conditions to Manchester for co-located specialist care, and may not be able to continue as the Maternal Medicine Centre for C&M without the required infrastructure, expertise and support. A snowball effect may follow the loss of any complex obstetrics and gynaecology services from Liverpool due to the loss of reputation and consequent difficulties with recruitment and retention of senior medical staff. This could significantly affect higher risk obstetric services in Liverpool and would necessitate a region-wide clinical reconfiguration. Any major impact on obstetrics services in Liverpool would also create a higher residual level of risk for women experiencing acute emergencies.

Current Controls		Rating	
Policies	N/A		
Processes	Establishment of Clinical Leaders Group and clinical engagement forum; NHSE Service Change Assurance Process	G	
Plans	C&M Joint Forward Plan 2023-2028; NHSE 3 year delivery plan for maternity plan (2023)); Programme engagement plan(s)	G	
Contracts	N/A		
Reporting	Regular reports to the Programme Board, WSC, Provider Trust Boards (LWFT, LUHFT, AHCFT, CCCFT) and Liverpool Joint 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]			
Actions planned	Owner	Timescale	Progress Update
Clinical Leaders Group (CLG) to lead model of care work on behalf of programme board.	CLG	Autumn 24 -Complete	Engagement event 2 (design) planned for December.
Specialised commissioning and clinical network leads to be involved in design	CLG	Autumn 24 -Complete	Included in invitations.
Clinical engagement event 2 – model of care – planned for December	CLG	Dec 24	
Finance, estates, workforce and digital workstreams to support model of care design and modelling work	CP	From Dec 24	

Capital and revenue implications of future model of care, interim model of care and counterfactual case (do nothing) to be worked up	Finance grp	From Jan 25	
Support for model of care from Liverpool and C&M NHS leaders to be sought	FL / LG / JS	Spring / Summer 25	

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances		
Planned	Actual	Rating
Women's Services in Liverpool Programme updates to ICB Women's Services Committee	Women's Services Committee – 3/7/24 & ICB Board – 9/10/24	Partial Assurance
As required, independent clinical senate to review case for change, model of care, options appraisal and business case.		
NHS Service Change Assurance – Stages 1 & 2 (dates TBC)		
Gaps in assurance <i>[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]</i>		
Work to develop model of care yet to be concluded		
Actions planned	Timescale	Progress Update
Actions as described above to conclude model of care	Summer 25	

ID No: T2	Risk Title: Impact on health outcomes and inequalities through limited Access to Specialist Weight Management Services across Cheshire and Merseyside and litigation in non compliance with NICE Technology Appraisals in relation to GLP1 Weight Loss Drugs
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	Likelihood	Impact	Risk Score	Trend
Initial Risk Score <i>[assess on 5x5 scale, this is the score before any controls are applied]</i>	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		
Fiona Lemmens	Neil Evans	Medical / ACE	Strategy and Transformation		
Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response	
Improve Population Health	Quality	A – within 3 months	Corporate	Manage	
Date Raised	Last Updated	Next Update Due			
January 2024	11/12/24	15/04/25			

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]*

Across Cheshire and Merseyside we have nine separately commissioned Specialist Weight Management Services (referred to as Tier 3). These services are included in the current NICE Guidance (CG189) and provide specialist support to patients with complex support needs in

relation to weight management, including being a mandated part of the pathway for people seeking/requiring bariatric surgery or prescribing of GLP1 Weight Loss Drugs.

Historically services in Liverpool, Knowsley, Halton and St Helens have been commissioned by the Local Authorities however in line with statutory responsibility sitting with the NHS the Local Authorities have served notice on this provision (other than Knowsley where this hasn't impacted in 2024-25). Interim funding arrangements have been required to maintain interim skeleton services. Further work is required as a minimum to avoid total absence of services in these Places in 2025-26.

In the other five Places we have minimal service access levels and variable funding and service models and across all 9 Places need/demand far outstrips capacity leading to extended waits and acceptance criteria thresholds being raised well above recommended NICE standards, as well as being inconsistent.

No service is currently providing access to GLP1 medication (TA 664 and TA875 and pending TA11156) and the capacity and prescribing costs are currently assessed as unaffordable in Cheshire and Merseyside and would require significant investment. Cheshire and Merseyside was due to be a pilot site (nationally funded) for implementation of this prescribing model in primary care but NHS England withdrew the pilot due to the pending TA – which is due to include primary care prescribing as a routine prescribing approach)

The picture described above is not unique to Cheshire and Merseyside and the ICB is working with NHS England (Obesity Team) and peer ICBs to identify approaches that may allow development of Tier 3, wider weight management services and prescribing of GLP1 medications. It has been confirmed that NICE will approve the TA for Tirzepatide on 23rd December with 90 days to implement (180 days for prescribing in Primary Care). This will be followed with a publication of revised NICE guidance for SWMS on 14th January and a commissioning Policy by NHS England (draft January and final in February). Alongside the commissioning policy will be ICB financial allocations to implement the NICE TA. Draft plans will be refined to reflect the financial allocation and NICE guidance, commissioning policies during Quarter 4 2024-25.

During September 2024 ICBs across England were made aware that a company (Oviva) had been awarded a contract by an ICB in the South West which the Provider said fell within the “Right to Choose” contracting requirements as a digital provider of SWMS. NHS England have investigated and during October confirmed they believe this to be correct. This means patients from anywhere in England can be referred to the provider. Due to the absence of local capacity and no service prescribing GLP1 this has led to significant levels of enquiries from the Public and GPs requesting referrals to the Provider. At present this has been limited as we have issued a holding position to GPs pending the ICB Contracting Team validating the nature/compliance of the Oviva contract. The provider has been communicating intensively with both public and GPs to make them aware of the service and we are aware that some referrals have been made.

An interim ICB commissioning policy has been developed which has been reviewed by the Clinical Effectiveness Group and pending some revisions will be presented to the ICB Executive Team for approval. This will outline parameters for referral criteria to digital providers in

order to prioritise referrals to those with greatest clinical need. The Policy will need revising when the NICE guidance and NHS England Commissioning Policy is published in Quarter 4.

Current Control			Rating
Policies	NICE Obesity: identification, assessment and management Guidance (Updated July 2023); Technology Appraisal for Provision of Obesity Drugs; (CG189, TA 664 and TA875 and pending TA11156)		G
Processes	C&M Tier 3 Weight Management Group, including provider representation NHS England led Obesity Working Group and aligned ICB Working Group commencing work Sept 2024 supporting by NHS Confederation.		A
Plans	Development of a business case to invest in SWMS and delivery of NICE TA, this is dependent on confirmation national funding will be available to support the NICE TA.		R
Contracts	Nine separate contracts across 6 Providers all with different specifications		A
Reporting	The plans outlined below were reported to Board in January 2024 and Executive Team March 2024 but plans have been delayed due to identification of a future funding source and delays in the updates to NICE guidance.		A
Gaps in control <i>[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]</i>			
No C&M wide minimum service specification for the provision of Tier 3 Weight Management Services. Non compliance with NICE guidance (including Technology Appraisals) and implementation would require significant investment.			
Actions Planned	Owner	Timescale	Progress Update
A full review of the pathway and delivery of Specialist Weight Management Services is underway C&M	Neil Evans	Complete	Summary of current services captured
Development and adoption of a minimum Cheshire and Merseyside service specification for the provision of Tier 3 services.	Neil Evans/Adam Major	April 25	Workshop held in March outlining model, including ICB, LA, Providers and service users. Implementation is constrained by financial investment required.
Implementation of GLP1 through funding ringfenced for Tirzepatide roll out	Neil Evans/Adam Major	April 25	ICB are part of national working group and as an ICB directly working with NHS England Obesity Team to see if can attract national funding to implement both model and GLP 1 prescribing. Options appraisal and service model to be developed in line with NICE guidance, Technology Appraisals and NHS England Commissioning Policy.

Development of interim plans in the four Places where Local Authorities are withdrawing from commissioning services	Neil Evans and Place nominated leads"	April 25	Agreeing common approach to developing interim solutions that won't destabilise a single C&M approach in medium term. This will be revisited in light of NICE publication dates of 23 rd December <i>*Tony Mcleod, Danielle McCulloch, Neil Meadowcroft and Judith Neilson</i>
Validate Oviva contract with BNSSG ICB as complying with Right to Choose requirements. Based on the outcome of this work we will consider options to manage the scale of referrals e.g. compliance with locally defined clinical criteria.	Adam Major	January 25	Contract has been validated as meeting Right to Choose so commissioning policy and communications to be developed and approval sought from ICB Executive Team.

Assurances

Planned	Actual	Rating
The development of a robust options appraisal presenting options on how we can fully or partially mitigate the risks in relation to health outcomes, inequalities and litigation. Modelling of the impact (including financial) of Oviva being a Right to Choose Provider.	We have partial assurance in that there will be some national funding associated with the NICE TA for Tirzepatide implementation which will enable some mitigation of the risk by enabling the actions identified. As described above the key documents are expected to be published in January 2025 to allow this work to be progressed.	Partial

Gaps in assurance [areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

The NICE TA for Tirzepatide has been confirmed as 23 December 2024 and we are awaiting NHS England confirmation of the funding availability and national commissioning policy which is needed to develop a viable options appraisal.

The award of a Right to Choose contract in the South West means patient referrals/expenditure to a digital provider presenting an inconsistent offer to GLP 1 drugs to those in local services. This also means ICB investment could be targeted at lower priority patients and not into local services supporting the more complex patient needs.

Actions planned	Owner	Timescale	Progress Update
See above actions			

ID No: QU04 **Risk Title: Delays in recruitment to fill gaps in the Safeguarding Service may lead to failure to provide statutory functions and meet core standards resulting in patient harm**

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score <i>[assess on 5x5 scale, this is the score before any controls are applied]</i>	3	4	12	
Current Risk Score	2	4	8	
Risk Appetite/Target Risk Score	2	4	8	

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
16 ▲	12 ▲	8 ▲	3 ↔	16 ▲	6 ↔	9 ↔	9 ▲	8 ↔

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

Raised	Updated	Next Update Due
2023	Nov-2024	Apr-25

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]

If the ICB fails to meet its statutory responsibilities or ensure robust safeguarding staffing arrangements are in place to safeguard children, young people and adults at risk THEN avoidable harm could occur to vulnerable people, leading to 1) a breach of statutory duties to safeguard children, looked after children and adults at risk; 2) avoidable harm could occur to children, looked after children and adults at risk, and 3) reputational damage to the ICB.

12th January 2024: Halton Place – Denise Roberts advises no longer a risk at Halton Place			
Current Controls			Rating
Policies	ICB Safeguarding Children, children in care and adults at risk policy. Working Together to Safeguard Children (2023). Intercollegiate Guidance for: 1. Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. 2. Adult Safeguarding: Roles and Competencies for Health Care Staff, 3. Looked After Children: Roles and Competencies of Healthcare Staff.		G
Processes	Named GP roles filled in each place - maps and gaps identified; Consistent JDs across all 9 places; Full Designated Nurse/ Professional Safeguarding team in each place		A
Plans	Consistent payment across named GPs		G
Contracts	Extending current fixed term contracts, ICB Recruitment process for staffing gaps, working with MLCSU for contracting; Review existing Named GP contracts and service level agreements.		G
Reporting	Place-based safeguarding reports; Place reporting to System Oversight Board, ICS Quality and Performance Board		G
Gaps in control <i>[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]</i>			
Inconsistency of safeguarding staffing provision across our 9 places			
Actions planned	Owner	Timescale	Progress Update
Review of ICB Safeguarding Staffing Provision and address gaps	Eleri Lloyd Burns/ Sarah Martin	August 2024	Mapping and review in progress June 2024- Mapping of Safeguarding Roles undertaken and completed in line with the available safeguarding guidance. Role gaps shared with finance dept 27/6/2024 to work out costings required to fill gaps.
Assurances			
Planned		Actual	Rating
Review and update of Named GPs JD's and contracts so they are the same across C&M		Complete and full Named GP provision in situ across the ICB	G
Identify Place gaps in Designated Doctor Provision		Agree recruitment process in each place to address gaps	A

Existing Designated doctors covering some gaps in provision as unable to recruit to vacancies	Full Designated Doctor Provision across C&M		A
Gaps in assurance [areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]			
Inconsistency of current Designated doctor provision across each Place. Working Together 2018 consultation was undertaken in September 2023 which will change the Designated Doctor job role requirements			
Actions planned	Owner	Timescale	Progress Update
Ensure the updated JDs for Designated Doctor role requirements reflect the updated Working Together to Safeguard children Stat Guidance	Sarah Martin	May 2024	June 2024WTG 2023 published and new job descriptions for new Designated Doctor roles written
MIAA Safeguarding audit to be undertaken to include staffing provision	Sarah Martin	April 2024	Audit undertaken in March/April 2024. Addressing gaps and vacancies of Designated Doctor provision highlighted as a recommendation from the audit especially for child death provision
Map current Designated Doctor provision across C&M and identify gaps	Sarah Martin	August 2024	HOS has started to map current provision across the 9 places to identify gaps in Designated Doctors. Once completed this will be discussed at Safeguarding Oversight Group. June 2024- Mapping of Safeguarding Roles undertaken in line with the available safeguarding guidance. Costing review now being undertaken with finance
Workforce review of safeguarding service and costings to be escalated to Execs for review	Chris Douglas/Kerry Lloyd	October 2024	
Develop and recruit to a new role of a ICB Merseyside Designated Doctor for Child Death to address gaps in provision	Kerrie France	December 2024	<p>May 2024- Job description, person spec and job advert developed and shared with the Merseyside Place ADQs to progress recruitment. Current Designated Doctors for Child Death covering Cheshire places contacted to see if they can cover current gaps in Merseyside with additional funded sessions until Merseyside role recruited to</p> <p>June 2024 Designated Doctors covering Cheshire have replied and are unable to offer additional session cover across</p>

			<p>Merseyside with their current substantive role and Designated doctor role commitments.</p> <p>Merseyside ADQs to consider meeting with Alder Hey Pediatric clinical leads to encourage if staff want to undertake this interim role with mentorship support from the Cheshire Designated Doctors for Child death until recruitment has been completed</p>
<p>Fill current vacancies in Designated Doctor for Looked after children in Halton and Liverpool</p>	<p>Denise Roberts / Amanda Williams</p>	<p>October 2024</p>	<p>No current Designated doctors can offer additional funded sessions to cover existing vacancies in Halton or Liverpool (Alder Hey have serviced notice for this role in Liverpool as cannot cover the sessions)</p> <p>Halton and Liverpool ADQs to consider meeting with their local trusts to see if they can supply the staff to undertake the role</p>

ID No: QU05	Risk Title: Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm
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	Likelihood	Impact	Risk Score	Trend
Initial Risk Score <i>[assess on 5x5 scale, this is the score before any controls are applied]</i>	5	4	20	<p>25 20 15 10 5 0</p> <p>Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May</p>
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 ↔	12 ↔	12 ↔	8 ↔	16 ↔	16 ▲	16 ↔	16 ↔	16 ▼

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

Raised	Updated	Next Update Due
2023	Nov-2024	Apr-2025

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]
<p>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:</p> <ol style="list-style-type: none"> 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	0-18 diagnostic pathways sit in Alder Hey block contract, additional capacity is subcontracted to Healios, non-diagnostic ASD support is via contract with Addvanced Solutions. 18+ ADHD diagnostic pathway is via contract with Cheshire & Wirral Partnership Trust, non-diagnostic support is via contract with Ladders for Life. Adult ASD diagnostic pathway is via contract with Mersey Care.	G	
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/		

	Transformati on ADQs		
Assurances			
Planned		Actual	Rating
NHSE Baseline assessment of demand, data, demographics etc.		Q&P key issues reporting- monthly standard agenda item	G
Performance is reported into all Trust CQRMs, Quality & Performance meetings at Place and SEND Partnership Board Performance Group (Place SEND governance)		Performance data for all age ASD and ADHD diagnostic pathways is available and reported Performance data for support services is available and reported	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	Timescal e	Progress Update
SEND Lead to provide focus report to Q&P Committee (frequency to be agreed)	Julie Hoodless	TBC	

ID No: WSC6 If patient safety, quality risks and clinical issues in the current women’s services model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely, with a greater impact on the socially deprived and those from ethnic minority groups.

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score <i>[assess on 5x5 scale, this is the score before any controls are applied]</i>	4	5	20	
Current Risk Score	3	5	20	
Risk Appetite/Target Risk Score	2	4	8	

Senior Responsible Lead	Senior Responsible Lead	ICB Directorate	Responsible Committee
Christine Douglas / James Sumner	Lynn Greenhalgh / Natalie Hudson / Oliver Zuzan	Nursing and Care	Women’s Services Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequalities in access, outcomes and experience Improving Population Health and Healthcare	Quality	A – within next quarter	Corporate	Manage

Date Raised	Last Updated	Next Update Due
17/01/2024	20/11/2024	15/04/25

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 case for change sets out the clinical risks the programme is seeking to resolve. These risks are driving the Women’s Hospital Services Programme to find solutions that enable the long-term clinical sustainability of these services, as well as identifying short and medium term solutions to reduce clinical safety and quality risks and support the stability of services.			
Current Controls			Rating
Policies	Patient Safety Incidence Response Framework (PSIRF)		G
Processes	LUHFT / LWFT individual boards and Partnership Board oversight of clinical risks / issues. Local CQPGs and Quality forums; LMNS ICB monitors and oversees safety ambition trajectories and outlier status of providers		G
Plans	LWFT Improvement Plan		G
Contracts	Standard NHS Contract; Specialised services contracts; NHSE Maternal Medicine Network Centre contract.		G
Reporting	Reporting to System Oversight Group, Programme Board, WSC, Provider Trust Boards (LWFT, LUHFT, AHCFT, CCCFT) and Liverpool Joint Committee.. Exception reporting to NHS C&M ICB.		G
Gaps in control [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
Deliver LWFT improvement plan that includes short term actions and mitigations.	JS	From Feb 24 - Complete	LWFT Trust Board, System Oversight Group, Programme Board and WSC have had updates. Programme Board SRO report to all key stakeholders in March. Routine reporting into WSC on progress.
Clinical design work for medium and long term in programme plan for winter.	CP	From Dec 24	Clinical engagement event 2 – model of care – planned for December
Health inequalities in outcomes to be a key factor in design work.	CP	From Dec 24	And included in case for change.

Insights from hard-to-reach groups and equalities groups to be reflected in design work.	CP	From Dec 24	Public engagement feedback / VCFSE orgs feedback / Lived Experience Panel feedback to be considered in design process.
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To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances			
Planned	Actual		Rating
Women's Services in Liverpool Programme updates to ICB Women's Services Committee	Plan for short term mitigations of safety and quality risks in place and being managed by LWFT and the LWFT / LUHFT Partnership Board.		Acceptable
Quality reporting to Quality & Performance Committee & ICB Board	ICB Board – 30/5/24,25/7/24,26/9/24, 28/11/24		
Executive Director of Nursing & Care report to ICB	ICB Board – 30/5/24,25/7/24,26/9/24, 28/11/24		
Gaps in assurance [areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]			
		Timescale	Progress Update

ID No: F8		Risk Title: As a result of increasing demands, inflationary pressures and restricted options / inability to deliver recurrent efficiency savings, there is a risk of significant overspends against the Place budget which may affect the ICB's ability to meet statutory financial duties.						
		Likelihood	Impact	Risk Score	Trend			
Inherent Risk Score <i>[assess on 5x5 scale, this is the score without any controls applied]</i>		5	5	25				
Current Risk Score		5	4	16				
Target Risk Score		4	3	12				
Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
12	12	12	8	12	12	8	8	16

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee		
Place Directors	Place ADOFs	Place Directorate	Finance, Investment & Our Resources		
Strategic Objective		Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity and Value for Money		Finance	B – within 12 months	Place	Manage
Date Raised		Last Updated		Next Update Due	
April 2024		20/12/24		15/04/25	

Risk Description (max 100 words)
The potential for significant overspends against place budgets is a risk in common escalated by multiple places, driven by increasing demand, inflationary pressures, and restricted options, delays in or inability to deliver efficiency savings. Taken collectively this may affect the ICB's ability to meet statutory financial duties.

Current Controls		Rating	
Policies	ICB SORD, SFIs, detailed financial policies	G	
Processes	Budget setting, financial monitoring & control, appointment of / allocation to budget holders / managers	A	
Plans	Annual financial plan & place allocations, recovery & efficiency plans	A	
Contracts	Contracts with NHS & other providers	A	
Reporting	Place SLT & Finance Groups, Finance, Investment and Our Resources Committee, ICB Board	G	
Gaps in control			
<p>Nationally prescribed budget setting assumptions insufficient to meet anticipated costs e.g. inflation Inherent or inherited deficit positions in some places require recovery plans / recurrent efficiency savings Unanticipated increases in demand and / or costs Gaps / delays / reductions in planned efficiencies</p>			
Actions planned	Owner	Timescale	Progress Update
Oversight of financial position & efficiency delivery	Place SLTs	2024-25	
Place based financial / recovery plans	Place ADoFs	2024-25	
Place based actions as indicated by specific place risks	Place ADoFs	2024-25	

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances			
Planned	Actual		Rating
Finance Reports to Finance, Investment & Resources Committee	Monthly – April to December 2024		Partial Assurance
Finance Reports to ICB Board	25/7/24, 26/9/24, 28/11/24		
Gaps in assurance			
Month 6 position indicated deficits for all 9 places, totaling £29.6m.			
Actions planned	Owner	Timescale	Progress Update
Place based financial / recovery plans	Place ADoFs	2024-25	
Place based actions as indicated by specific place risks	Place ADoFs	2024-25	

ID No: PF1		Risk Title: Demand, capacity and flow challenges across the wider urgent and emergency care system, spanning primary care, community and mental health care and social care, resulting in high levels of NCTR patients could result in risk of patient harm and poor experience of care						
		Likelihood	Impact	Risk Score	Trend			
Inherent Risk Score <i>[assess on 5x5 scale, this is the score without any controls applied]</i>		5	5	25				
Current Risk Score		4	5	20				
Target Risk Score		3	5	15				
Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
12	20		9	20		16	16	20

Senior Responsible Lead		Operational Lead		Directorate		Responsible Committee	
Place Directors		ADTPs		Place Directorate		Quality & Performance	
Strategic Objective			Function		Risk Proximity	Risk Type	Risk Response
Tackling Health Inequalities in Outcomes, Access and Experience			Performance / Quality		A – within 3 months	Place	Manage
Date Raised			Last Updated			Next Update Due	
Nov / Dec 2023			20/12/24			31/01/25	

Risk Description (max 100 words)
The potential for patient harm and poor experience of care due to restricted patient flow across the integrated care system is a risk in common escalated by multiple places. This is driven by increased presentations at ED, and across the system combined with workforce capacity limitations, excess bed days due to no criteria to reside patients and higher levels of acuity, resulting in reduced flow from emergency departments into the acute bed base and is in turn impacting on waiting times in the Emergency Department (ED), compounding the need for corridor care, ambulance handover delays and failure to meet the 15-minute ambulance response time standard. 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 EDs. Noting that this is a whole system issue spanning primary care, community and mental health care and social care is under significant pressure with similarly high levels of acute complex frailty demand, capacity limitations (particularly within sectors of the market such as domiciliary care and EMI Nursing Homes).

Current Controls		Rating	
Policies	National Policy framework, standards & guidance applied at place via Discharge Policy, UEC Standards, Long waits guidance, Risk stratification, FNC / CHC framework, D2A guidance, SCC guidance, Fuller report, Choice Policy, OPEL Framework (Place action cards)	G	
Processes	NHS Oversight Framework, national UEC tiering and associated support; ICB System Coordination Centre; programme, performance & contract management; system wide & place level planning & weekly / daily protocols & systems to monitor, manage and escalate patient flow issues	A	
Plans	C&M Operational Plan, Winter Plan, Place Delivery Plans – 2024/25, System & Place UEC Recovery Programmes	A	
Contracts	NHS Standard Contract	G	
Reporting	Place oversight, SCC, UEC Recovery Programme, Quality & Performance Committee, ICB Board, regional/ national NHSE teams	A	
Gaps in control			
<p>Demand and acuity exceed planned capacity levels in a range of sectors, and fuller understanding of demand and capacity across all sectors is required.</p> <p>Workforce shortages in some sectors across multiple places, including industrial action.</p> <p>Data Quality / Gaps to ensure all delays and numbers are recorded at place level & Quality dashboard.</p> <p>Synthesis & consistency of policy into action / variations in process & offer</p> <p>Local ability to influence root cause of some delayed discharge for Complex Patients/pathways</p>			
Actions planned	Owner	Timescale	Progress Update
UEC Recovery Programme	SROs	2024-25	Recovery programmes underway and on track including at scale workstreams, Liverpool, Mersey & West Lancashire, Cheshire, Warrington & Halton, Wirral
Place Delivery Plans / Improvement Plans	Place Directors	2024-25	Underway in all places

Place based actions as indicated by specific place risks	Place Directors & SLTs	2024-25	Updates provided via specific place risks
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To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances				
Planned		Actual		Rating
UEC Recovery Programme Board reports at system & place		Fortnightly reporting – April to Dec		Partial
Place Based Partnership Board reporting		Monthly / Bi-monthly reporting – Apr to Dec		
Integrated Performance Report to Q&P Committee & ICB Board		ICB Board – 30/5, 25/7, 26/9, 28/11		
Gaps in assurance				
Performance against the majority of urgent and emergency care measures is below target and England average. Issues with quality of data identified on some place risks Requirement to review / further develop plans identified on some place risks				
Actions planned	Owner	Timescale	Progress Update	
Urgent Care Improvement Programmes at place	Place Directors	2024-25	Recovery programmes underway	
Place based actions as indicated by specific place risks	Place Directors & SLTs	2024-25	Updates provided via specific place risks	

ID No: PDAF 2 **Risk Title: The Wirral health and care system is unable to meet the increasing needs of children and young people with complex and/or additional needs leading to long term health issues, increased inequalities and demands on services.**

	Likelihood	Impact	Risk Score	Trend
Inherent Risk Score <i>[assess on 5x5 scale, this is the score before any controls are applied]</i>	5	4	20	
Current Risk Score	4	4	16	
Target Risk Score	2	4	8	
Risk Appetite	Risk Appetite to be agreed across NHS C&M due to multiple places sharing the risk.			

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Place Director, NHS Cheshire and Merseyside	Joint Commissioning Lead for CYP, Wirral Council and NHS C&M	Transformation and Partnerships	Wirral Place Based Partnership Board

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Strategic Objective 1: Tackling Health Inequalities in Outcomes, Access and Experience	Quality, transformation and commissioning	C- Beyond financial year	Transformation and Partnership	Manage and mitigate

Date Raised	Last Updated	Next Update Due
25 th August 2023	29 th November 2024	28 th February 2025

Linked Wirral Plan 2026 objective(s)	Brighter Futures: Working together for <i>brighter futures</i> for our children, young people and their families by breaking the cycle of poor outcomes for all regardless of their background.
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	<p>Safe and pleasant communities: Working for <i>safe and pleasant communities</i> where our residents feel safe and are proud to live and raise their families.</p> <p>Active and healthy lives: Working to provide happy, <i>active and healthy lives</i> for all, with the right care, at the right time to enable residents to live longer and healthier lives.</p>
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Risk Description	
An Increased in demand and complexity of children and young people which since the pandemic which I outstripping capacity in current NHS and LA provision.	
Linked operational risks	The operational Risk Registers are being developed.

Current Controls		Rating
Policies	HR Policies. Operational policies and SEND code of practice. CHC national framework. Safeguarding. Mental Health Act. Children's Act.	Green
Processes	CYP mental health escalation framework. DSD data base. Neurodevelopmental pathway. AACCC Children's framework SEND Local Offer - SENDLO	Amber
Plans	SEND Written Statement of Action (WSOA) - Action Plan. CYP mental health transformation. SEND Improvement Plan	Amber
Contracts	NHS Standard Contract. Local Authority contract	Green
Reporting	Children, Young People and Education Committee. SEND Partnership Board. Health and Wellbeing Board. Wirral Place Based Partnership Board. Children Safeguarding Partnership. Quality and Performance Group. Contract meetings. Strategy and Transformation Group.	Green
Gaps in control		
Knowledge of future needs of population. Preparation for re-inspection of SEND with a view to progress against the Written Statement of Action (WSOA), and removal of the Improvement Notice by October 2025. Pathways and services for CYP with complex needs that provide alternatives to care, custody or inpatient admission through anticipatory care.		

Actions planned	Owner	Timescale	Progress Update
Demand modelling and provision agreement	Joint Commissioning Lead for CYP (Wirral Council and NHS C&M)	<p>Aug 24 Oct 24</p> <p>April 25</p> <p>March 25</p>	<p>DBV and JSNA have given a better understanding of data. Review of service specifications to identify gaps in provision. Review of services – SALT, OT, ND pathway & EHWP.</p> <p>New model developed for ND Pathway & EHWP with new data sets to inform revised dashboard. Complete</p> <p>SALT waiting list management and EHCP provision business cases agreed, and implementation has begun (Aug 2024) – bi-weekly monitoring of progress in place. Trajectories have been developed that identify recovery timescales.</p> <p>DBV funding £200k to be invested in developing alternative health delivery models in the Graduated Approach to support early intervention and prevention and reduce escalation to specialist services.</p>
Action planning for SEND reinspection and delivery of WSOA action plan.	Director, Children's Services (Wirral Council) and Associate Director, Quality and Patient Safety NHS C&M	<p>Sept 2024</p> <p>Dec 2024</p>	<p>QA process for WSoA – moving into Inspection preparation and readiness review against new framework. Ensuring collection of evidence that demonstrates positive outcomes and impact. New subgroups of SEND Partnership Board – continuous improvement, Performance management and WSoA will scrutinise and report on progress to SEND Partnership Board.</p> <p>Self-assessment produced that reflects multi-agency working.</p>
<p>Development of care pathways and provision and commissioning activity.</p> <p>1. Central point of access (CPA) for emotional health & wellbeing needs CYP branded 'Branch'</p>	Joint Commissioning Lead for CYP	Nov 2024	<p>1. Alliance contract awarded start date April 2024. Digital Platform in development with digital agency Kaleidoscope. Branding 'Branch' coproduced with CYP. Full launch took place Nov 2024. Complete</p>

<p>2. Implementation of the ND model</p> <p>3. Development of alternative health delivery models in universal settings (DBV)</p> <p>4. Establishment of balanced system model for speech and language</p> <p>5. Available provision for high-risk complex young people and associated integrated care planning.</p>		<p>Dec 2024</p> <p>April 2025</p> <p>March 25</p> <p>April 24</p> <p>March 2025</p>	<p>2. New model agreed and waiting to be implemented Business cases have been submitted for new model but paused due to ICB financial recovery. Complete New business case to be developed for next financial year 25/26..</p> <p>3. Funding bid agreed by DFE to develop an early intervention health delivery model which will increase early support in mainstream settings and promote inclusivity.</p> <p>4. SALT system steering group in place with action plan and timescales agreed. Steering group part of DBV work.</p> <p>5. DSD and MH gateway -combined to mitigate risks of duplication and gaps. And to proactively manage risks and jointly care plan. Complete Proposed development of provision to support high risk cases in progress. Lyndhurst ASD/LD provision underway.</p>
<p>Governance of quality, safety performance and risk of children and young people</p>	<p>Director, Children's Services (Wirral Council) and Associate Director, Quality</p>	<p>Sept 2024</p>	<p>Review of children and young people's governance arrangements – bringing together performance, quality, risks and improvements from Public Health, ICB (Wirral Place) and LA Children's Services</p> <p>Revised Governance arrangements in place for SEND in light of Improvement notice (May 2024) Complete</p>

	and Patient Safety NHS C&M		
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Assurances			
Planned		Actual	Rating
New SEND Performance Reporting framework and revised dashboard and SEND Partnership Board replacing Transformation Board		Established	Reasonable
SEND Strategy and Outcomes Framework		In progress	
Progress on CYP priorities from Health and Care Plan monitored through programme reporting to Strategy and Transformation Group		Programme reporting to Strategy and Transformation Group.	
Development of EHWB model and ND model		Completed	
Implementation of ND model		Planned delivery August 24 DELAYED	
Clearance of waiting times		Planned delivery June 24 DELAYED	
Governance arrangements		In place	
Priority area Identified locally and as part of NHS C&M recovery programme		Established- PID in place	
Gaps in assurance			
Removal of WSOA by Office for Standards in Education, Children's Services and Skills (OFSTED). Improvement Notice issued May 2024.			
Actions planned	Owner	Timescale	Progress Update
Implementation of ND pathway and clearance of waiting times	Commissioning Lead for CYP (Wirral Council and NHS C&M)	April 2025	Business cases submitted – paused due to ICB financial recovery. Front door will move to WUTH and WUTH to develop implementation and recovery plan – business case being

			prepared for Dec 2024 for next financial year 25/26. Bid submitted to TCP to support waiting list.
SEND Strategy and Outcomes Framework	Commissioning Lead for CYP (Wirral Council and NHS C&M)	Dec 2024	High-level outcomes and strategic priorities identified. Outcomes framework almost complete. Strategy due Dec 2024.
System meeting requirements to assure DfE for removal of Improvement Notice.	Director, Children's Services (Wirral Council) and Associate Director, Quality and Patient Safety NHS C&M	October 2025	Monthly SEND Board established chaired by CEO. 6 monthly progress meetings with DfE.

ID No: PDAF 2 Place Risk ID 150	Halton Place Partnership System is unable to meet the needs of children and young people with complex and/or additional needs leading to long term health and care issues, increased inequalities and demands on services.																													
	Likelihood	Impact	Risk Score	Trend																										
Initial Risk Score <i>[assess on 5x5 scale, this is the score before any controls are applied]</i>	4	4	16	<table border="1" style="display: none;"> <caption>Risk Score Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Apr</td><td>16</td></tr> <tr><td>May</td><td>16</td></tr> <tr><td>Jun</td><td>16</td></tr> <tr><td>Jul</td><td>16</td></tr> <tr><td>Aug</td><td>16</td></tr> <tr><td>Sep</td><td>16</td></tr> <tr><td>Oct</td><td>16</td></tr> <tr><td>Nov</td><td>16</td></tr> <tr><td>Dec</td><td>16</td></tr> <tr><td>Jan</td><td>12</td></tr> <tr><td>Feb</td><td>12</td></tr> <tr><td>Mar</td><td>12</td></tr> </tbody> </table>	Month	Risk Score	Apr	16	May	16	Jun	16	Jul	16	Aug	16	Sep	16	Oct	16	Nov	16	Dec	16	Jan	12	Feb	12	Mar	12
Month	Risk Score																													
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Mar	12																													
Current Risk Score	4	4	16																											
Target Risk Score	3	4	12																											

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee	
Anthony Leo Place Director	Associate Directors of: Quality & Safety Improvement – Denise Roberts Transformation and Partnerships – Philip Thomas	Halton Place	SEND Improvement Board One Halton Partnership Board	
Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tacking health inequalities in outcomes, access and experience in Halton	Quality & Safety Improvement Transformation and Partnerships	C beyond the financial year	Place	Manage
Date Raised	Last Updated	Next Update Due		
07/12/23	April 2024	03/07/24		
	26/06/24 – reviewed at SLT – no changes.	18/07/24		
	18/07/24 – reviewed at SLT – no changes.	15/08/24		

	15/08/24 – reviewed at SLT – no changes.	19/09/24
	<p>19/09/24 – reviewed at SLT – no changes.</p> <p>A further in-depth PDAF review was undertaken at SLT PLT on 23/09/24 where it was agreed the PDAF risks would be re-drafted by Anthony Leo and Nigel Gloudon.</p>	17/10/24
	24/10/24 – reviewed at SLT – no changes at present but will be updated in due course.	21/11/24.
	<p>15/11/24 following discussion between Anthony Leo and Dawn Boyer, this risk has been updated as per Tony's comments below:-</p> <p>In relation to the risks re children, this is a Place Partnership System risk (not just ICB @ Halton Place). We believe this reflects the level of collective, shared risk across the Place Partnership System rather than the risk borne just by ICB @ Halton.</p> <p>As a system, there have been inadequate inspections for both SEND (All Health Partners & LA) and ILACS (mainly LA). The risk is that if the partners do not collectively address the issues, the partnership will not meet the needs of local CYP – that is a collective responsibility, not just ICB @ Halton Place.</p>	19/12/24

	<p>This risk and score need to remain please with the following amendment to the narrative.</p> <p>HPDAF2 – Halton Place Partnership System is unable to meet the needs of children and young people with complex and/or additional needs leading to long term health and care issues, increased inequalities and demands on services, currently rated as extreme (16)</p> <p>Risk title/description updated.</p>	
	<p>19/12/24 reviewed at SLT – no changes at present but will be updated in due course.</p>	<p>16/01/25</p>

Risk Description
<p>Halton Place Partnership System is unable to meet the needs of children and young people with complex and/or additional needs leading to long term health and care issues, increased inequalities and demands on services.</p>

Linked Operational Risks	
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Current Controls		Rating
Policies	<p>SEND Strategy Operational policies.</p>	Amber
Processes	<p>Outcomes Framework Communications and Engagement Plan Strategic Planning Process with Partners Business intelligence/data analysis Programme and Project Management Updated Joint Strategic Needs Assessment</p>	Red
Plans	<p>SEND Strategy SEND Priority Action Plan with identified SROs</p>	Amber

Contracts	NHS Contracts Local Authority Contracts			Amber
Reporting	SEND Improvement Board Children's Safeguarding Partnership One Halton Partnership Board Health and Wellbeing Board Place Quality and Performance Group Contract Review Meetings			Red
Gaps in control				
<ol style="list-style-type: none"> 1. Strategic oversight and governance arrangements – to be embedded. 2. Efficient and high quality information gathering and sharing processes to ensure that children's and young people's needs are understood accurately and met more swiftly and effectively through coordinated approaches. 3. Effective joint commissioning of services to ensure that children, young people and their families receive sufficient support to have their needs met. 4. Early identification of needs and access to specialist health pathways, including the neurodevelopmental assessment pathway and speech and language therapy and the support available, while children and young people wait. 5. Timeliness of new EHC plans and updates to EHC plans following the annual review process, so that, if appropriate, children and young people receive an effective EHC plan within statutory timescales. 				
Actions planned	Owner	Timescale	Progress Update	
1. Priority Action Plans for SEND to be implemented and change embedded.	Director of Children's Services at HBC and Place Director/Priority Action SROs	30/04/24 15/08/24 19/09/24 17/10/24 21/11/24 19/12/24 Ongoing	Priority Action Plans developed for SEND priorities and approved by OFSTED/CQC. <u>Oversight and progress monitoring:</u> Delivery Group SRO regular meetings. Joint Management Oversight Group. Improvement Board to be established.	
Assurances				
Planned		Actual		Rating
Delivery and implementation of the SEND Priority Action Plan.		Improvement Plan approved by OFSTED/CQC. Now in implementation phase.		Reasonable

Evidence of progress against Priority Action Plans to be monitored by SEND Improvement Board and supporting governance arrangements.	Governance arrangements agreed and approved by OFSTED/CQC. First Board meeting on 17 April 2024.		
Gaps in assurance			
Over-arching governance agreed, but Improvement Board now needs to be implemented/embedded. Lack of established data flows and reporting to enable timely monitoring of progress.			
Actions planned	Owner	Timescale	Progress Update
2. Development of dashboard and on-going monitoring of PAPs to address action areas covering points 1 & 2.	SROs	On-going	In progress as part of developed PAP.
3. SEND Improvement Board arrangements to commence and become embedded as part of over-arching governance.	SROs	30/04/24 15/08/24 19/09/24 17/10/24 21/11/24 19/12/24 Ongoing	In progress. First meeting 17 April 2024.

Meeting of the Board of NHS Cheshire and Merseyside

30 January 2025

Reforming elective care for patients in Cheshire and Merseyside

Agenda Item No: ICB/01/25/22

Responsible Director: Anthony Middleton
Director of Performance and Planning

Reforming elective care for patients in Cheshire and Merseyside

1. Purpose of the Report

- 1.1 This report provides an overview of the new elective care reform plan issued on 06 January 2025 and the requirements placed upon Integrated Care Boards and NHS Elective Care Providers, and sets out an initial approach as to how these asks may be addressed.

2. Executive Summary

- 2.1 This report outlines the national elective care reform plan, Reforming Elective Care for Patients, published on January 6, 2025¹ and its implications for Integrated Care Boards (ICBs) and NHS Elective Care Providers.
- 2.2 The plan aims to improve elective care services and meet new national performance goals, including achieving an 18-week treatment standard by March 2029. By March 2026, 65% of patients are expected to wait less than 18 weeks for elective treatment, with a target of 92% by 2029.
- 2.3 The key expectations for the ICB include raising awareness of patient choice, targeting health inequalities, and transforming care pathways in key specialties.
- 2.4 NHS Elective Care Providers are tasked with improving patient experience, expanding the use of digital tools, and enhancing diagnostic capacity.
- 2.5 The Cheshire and Merseyside Acute and Specialist Trust Alliance (CMAST) will play a key role in taking forward the election reform agenda and aligning C&M efforts with national goals.
- 2.6 The elective reform plan aligns with ICB strategic objectives, including tackling health inequalities, improving healthcare, and enhancing productivity.
- 2.7 This report highlights the need to assess the feasibility of meeting these targets in the context of the current waiting list and available resources. There are potential risks and uncertainties at this point, particularly around financial implications, due to the timing of the operational planning guidance.

¹ <https://www.england.nhs.uk/publication/reforming-elective-care-for-patients/>

3. Ask of the Board and Recommendations

3.1 The Board is asked to:

- **note** the requirements for Integrated Care Boards and NHS Elective Care Providers set out in 'Reforming elective care for patients' and approve the high level approach to development of 2025/26 elective plans in collaboration between Cheshire & Merseyside Acute and Specialist Trust Alliance (CMAST) and the ICB.

4. Reasons for Recommendations

- 4.1 'Reforming elective care for patients', summarised in section 5 sets out a range of requirements for Integrated Care Boards and NHS Elective Care Providers including the headline deliverables that the ICB and NHS Elective Care Providers in Cheshire and Merseyside will be expected to deliver in 2025/26 and beyond.

5. Background

- 5.1 The Department for Health and Social Care and NHS England published 'Reforming elective care for patients' on 06 January 2025.

- 5.2 This national plan sets out the following key commitments:
- the NHS will meet the 18-week standard by March 2029.
 - by March 2026, the % of patients waiting less than 18 weeks for elective treatment will be 65% nationally.
 - every trust will need to deliver a minimum 5 percentage point improvement by March 2026.
 - every trust will then be expected to achieve sufficient increases annually to reach 92% in 2029.

- 5.3 To support achievement of these commitments, the plan is framed in terms of four key areas of focus:
- empowering patients
 - reforming delivery
 - delivering care in the right place
 - aligning funding, performance oversight and delivery standards.

- 5.4 Within each of these four focused areas, more detailed commitments and requirements are set out for NHS England, Integrated Care Boards, and NHS Elective Care Providers. These are detailed in the slides in Appendix One.

- 5.5 For Integrated Care Boards the key actions can be summarised as:
- ensure patient and carer awareness of new choice and experience expectations.

- set a vision for health inequalities reduction (in elective care) by March 2025, addressing underserved groups and waiting list challenges.
- implement CDC standards, direct referrals, straight-to-test pathways, and expand remote monitoring for Long Term Conditions, reduce follow-up appointments and optimise referrals/triage.
- transform care pathways in 5 priority specialties and align elective activity targets with local commissioning arrangements by September 2026.

5.6 For NHS Elective Care Providers, the key actions are:

- appoint a director for improving care experience in each ICB and provider by April 2025; provide customer care training for non-clinical staff in patient-facing roles.
- ensure 85% of acute trusts allow patients to view appointment details via NHS App by March 2025 and make NHS App and Manage Your Referral the default route for elective provider choice.
- utilise new CDC diagnostic capacity, including extended hours and same-day tests/consultations and offer a range of responsive follow-up care options, including remote consultations, monitoring, and Patient Initiated Follow Up (PIFU) in all appropriate pathways by March 2026, with 5% PIFU uptake by March 2029.

5.7 The Cheshire & Merseyside Acute and Specialist Trust Alliance (CMAST) leads on elective recovery and transformation for C&M, and hosts both the diagnostic programme and the elective recovery and transformation programme.

5.8 The majority of actions required of ICBs and providers sit naturally within the pre-existing programme structure and the ICB and CMAST will continue to work collaboratively to deliver on this agenda.

5.9 To put the new national performance ambitions in context, in Cheshire & Merseyside, as at November 2024, there were 366,053 patients on the waiting list, of whom 209,962 or 57.4% had been waiting less than 18 weeks. A 5% improvement in performance will therefore bring C&M performance to 62.4%, short of the 65% national ambition.

5.10 The broad implication of achieving 65% of patients waiting less than 18 weeks is that an activity increase of 6.8% is needed in order to reduce the number of patients waiting longer than 18 weeks by approximately 43,500. The feasibility of this needs to be assessed in the light of the 2025/26 planning guidance and financial envelope, once these are published and understood, as we will be moving from a post COVID scenario in which there was effectively no cap on elective activity up until 2024/25, into a more constrained context.

5.11 In developing plans to meet these headline ambitions, CMAST will be building on the work it is already doing (see 7.1) to identify further opportunities in terms of reducing onward referrals and follow up activity, whilst also improving productivity both in outpatients and in terms of theatre productivity, all of which will contribute to improved referral to treatment times.

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 plans outline specific measures to improve patient experience, ensure that the public are aware of the elective care offer they should expect to receive, and to target health inequalities.*
- Objective Two:** **Improving Population Health and Healthcare:** *The elective plan aligns to the ICB's aim to provide high quality, accessible and safe services*
- Objective Three:** **Enhancing Productivity and Value for Money:** *Productivity is a key focus of the proposed plans, in terms of a package of measures to reduce demand, optimise referrals and triage, and reduce variation*
- Objective Four:** **Helping to support broader social and economic development:** *Delays in elective care are recognised not only as a factor impacting on patient quality of life but also in the wider context as a factor in rates of Economic inactivity (People not in employment who have not been seeking work within the last 4 weeks and/or are unable to start work within the next 2 weeks)*

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

- 7.1 The elective reform plans are relevant to the existing 2024/25 annual delivery plan objectives for elective and diagnostics as follows:
- delivery of the Elective Recovery plan to eliminate 65 week waits
 - onward Referrals: work towards targeting a 30% reduction in the number of onward referrals and reduce outpatient follow up activity by 25% against 2019/20 baseline
 - increase in day case activity, targeting 85%, in line with C&M plan
 - work to improve Theatre Utilisation - deliver planned, system average Theatre utilisation of at least 80%
 - diagnostics: Increase % of patients that receive a diagnostic test within six weeks in line with March 2025 ambition of 95%.
 - support plans to address elective and cancer backlogs and the diagnostic waiting time ambition.
 - continued work to support expanding CDCs
 - network productivity - Deliver a minimum 10% improvement in pathology and imaging networks productivity by 2024/25 through digital diagnostics investments.
- 7.2 As plans are developed for 2025/26, these will be refreshed and updated.

8. Link to meeting CQC ICS Themes and Quality Statements

8.1 The elective reform plans are relevant to quality themes as follows:

Theme One: Quality and Safety

- QS4 Equity in access
- QS5 Equity in experience and outcomes

Theme Two: Integration

- QS7 Safe systems, pathways and transitions
- QS8 Care provision, integration and continuity
- QS9 How staff, teams and services work together

Theme Three: Leadership

- QS10 Shared direction and culture
- QS13 Governance, management and sustainability

9. Risks

9.1 The new national elective plan/guidance is relevant to addressing Board Assurance Framework risk P3: Service recovery plans for Planned Care are ineffective in reducing backlogs and meeting increased demand which results in poor access to services, increased inequity of access, and poor clinical outcomes.

9.2 Of note, due to the timing of the guidance and sequencing of publications in relation to the 2025/26 operational planning round, it is not possible to fully assess the affordability of delivering the headline commitments around 65% RTT performance and/or a 5% improvement in performance at provider level.

10. Finance

10.1 As at the time of writing, the operational planning guidance for 2025/26 has yet to be published.

10.2 Therefore, at this time, it is not possible to properly assess the financial impact of implementing the actions set out in the guidance, and how this will sit within the context of the wider mandate that is set for the NHS. Given that finances are certain to be constrained in 2025/26, the affordability of these commitments is a key risk.

11. Communication and Engagement

- 11.1 CMAST is undertaking engagement with Cheshire & Merseyside acute and specialist providers in relation to this new guidance and will lead on development of supporting plans to address provider actions.

12. Equality, Diversity and Inclusion

- 12.1 The new guidance is framed in terms of reducing health inequalities and places an explicit expectation on ICBs that they will set a vision for health inequalities reduction and ensuring patient and carer awareness. CMAST has already led on work to address health inequalities for elective patients, using risk stratification tools. This aligns also with ICB Priority One: Tackling Health Inequalities in access, outcomes, and experience.

13. Climate Change / Sustainability

- 13.1 There are no direct climate change or sustainability implications associated with the content of this report.

14. Next Steps and Responsible Person to take forward

- 14.1 Next steps: Anthony Middleton, Director of Performance and Planning and CMAST to take forward development of Cheshire & Merseyside plans to respond to 'Reforming elective care for patients' in the context of the 2025/26 operational planning round.

15. Officer contact details for more information

- 15.1 Anthony Middleton, Director of Performance and Planning

Appendix One:

Reforming elective care for patients – January 2025 – summary of commitments and requirements

Headline Commitments



Cheshire and Merseyside

1. The NHS will meet the 18-week standard by March 2029.
2. By March 2026 the % of patients waiting less than 18 weeks for elective treatment will be 65% nationally.
3. Every trust will need to deliver a minimum 5 percentage point improvement by March 2026.
4. Every trust will then be expected to achieve sufficient increases annually to reach 92% in 2029.

To meet the 18-week standard and reform elective care by March 2029, we are focusing on:

- i. **Empowering patients** giving more choice and control and establishing the standards patients can expect to make their experience of planned NHS care as smooth, supportive and convenient as possible
- ii. **Reforming delivery** by working more productively, consistently and differently– to deliver more elective care
- iii. **Delivering care in the right place** so patients receive care from a skilled workforce in the right setting
- iv. **Aligning funding, performance oversight and delivery standards**, with clear responsibilities and incentives and clear expectations for how elective care will be delivered at a local level.

Empowering Patients



Cheshire and Merseyside

1. NHS England will:
 - i. Publish minimum standards for elective care experience for patients, carers, and representatives – **September 2025**
 - ii. Promote and monitor patients' right to choose when and where they receive care
 - iii. Collate and publish data to improve uptake of national health inequalities initiatives – **2025/26**
 - iv. Expand NHS App & Manage Your Referral website to improve information & appointment management for patients and carers – **March 2027**
 - v. Work with providers to make NHS App and Manage Your Referral the default route for choosing an elective provider
2. **Integrated Care Boards will:**
 - i. **Ensure patients and carers are aware of new experience expectations for elective care and their right to choose care – September 2025**
 - ii. **Set a local vision to reduce health inequalities and address waiting list challenges for underserved groups – March 2025**
3. NHS Elective Care Providers will (role for CMAST) :
 - i. Appoint a director responsible for improving care experience in each ICB and provider – **April 2025**
 - ii. Offer customer care training for non -clinical staff in patient -facing roles to support effective booking and waiting list management
 - iii. Implement local interventions to reduce disparities in healthcare access
 - iv. Ensure 85% of acute trusts allow patients to view appointment details via NHS App by **March 2025**
 - v. Significantly expand NHS App by **March 2027** to enhance information for patients and carers, including proxy access
 - vi. Make NHS App and Manage Your Referral the default route for elective provider choice



Compassionate



Inclusive



Working Together



Accountable

Reforming delivery

1. NHS England will:
 - i. Launch 17 new and expanded surgical hubs for quicker access to common surgical procedures– **June 2025**
 - ii. Improve elective pathways by extending CDCs’ operating hours (12 hrs/day, 7 days/week) and offering same day tests, consultations, and direct referrals – **March 2026**
 - iii. Boost bone density scanning (DEXA) capacity with up to 13 new scanners, providing 29,000 extra scans
 - iv. Introduce a new Partnership Agreement with the independent sector to help reduce waiting lists– **Jan 2025**
2. **Integrated Care Boards will:**
 - i. **Implement new CDC standards, increasing direct referrals and rolling out at least 10 straight-to-test pathways – March 2026**
 - ii. **Ensure contracts with the independent sector to address waiting list challenges and expand diagnostic tests**
3. NHS Elective Care Providers (CMAST) will:
 - i. Utilise new CDC diagnostic capacity, including extended hours and increased same-day tests and consultations
 - ii. Provide a range of responsive follow-up care options, including remote consultations, monitoring, and digital support for patient-initiated follow-up (PIFU) across major specialties

Care in the right place

1. NHS England will:
 - i. Fund primary & secondary care to deliver Advice and Guidance (A&G), with £20 per request for GPs to enhance patient care in the right setting, reducing elective waiting lists. **Expect 4 million A&G requests in 2025/26.**
 - ii. Support A&G optimisation with metrics, dashboards, and toolkits.
 - iii. Establish collective care models, such as group appointments and onestop clinics – **September 2025.**
 - iv. Reform care in 5 specialties (**ENT, gastroenterology, respiratory, urology, cardiology**).
 - v. Expand and improve Federated Data Platform (FDP) products, reaching 85% adoption by **March 2026.**
 - vi. Expand NHS e-RS and NHS App to optimise referrals and patient choice.
2. **Integrated Care Boards will:**
 - i. **Optimise A&G referrals and triage, ensuring appropriate care settings- March 2026.**
 - ii. **Expand remote monitoring for LTCs, removing 500,000 followup appointments per year from 2026/27.**
 - iii. **Standardise referral criteria and implement triage procedures for highvolume specialties.**
 - iv. **Focus on reducing discharge variation and expand self-management tools– September 2026.**
 - v. **Transform care pathways in 5 priority specialties (ENT, gastroenterology, respiratory, urology, cardiology).**
3. NHS Elective Care Providers (CMAST) will:
 - i. Offer Patient-Initiated Follow-Up (PIFU) in all appropriate pathways – **March 2026.**
 - ii. Increase PIFU uptake to 5% of outpatient appointments, using AI and automation– **March 2029.**
 - iii. Implement collective care models with group appointments and one-stop clinics.
 - iv. Work with systems to standardise referrals, maximise A&G, and implement triage in highvolume specialties.



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Aligning funding, performance oversight and delivery standards

1. NHS England will:
 - i. Update the Payment Scheme to focus on activities that directly reduce patient wait times and introduce relevant tariffs.
 - ii. Run a capital incentive scheme for providers improving RTT standards.
 - iii. Deliver NHS IMPACT Clinical and Operational Excellence Programme, training 8,000+ leaders in elective pathway management – **March 2026**.
 - iv. Implement strong performance oversight, including tiering, for greater transparency in elective care delivery.
 - v. Set expectations for outpatient activity in job planning, detailing clinician roles, including community sessions.

2. **Integrated Care Boards will:**
 - i. **Reflect elective activity targets and funding allocations in local commissioning arrangements.**

3. NHS Elective Care Providers (CMAST) will:
 - i. Implement performance management for elective targets, using NHS IMPACT support and national metrics.
 - ii. Collaborate with system partners to adopt best practices, including reformed pathways, improved clinical job planning, and partnerships with the independent sector.



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Meeting of the Board of NHS Cheshire and Merseyside

30 January 2025

Cyber Security Update

Agenda Item No: ICB/01/25/23

Responsible Director: John Llewellyn
Chief Digital Information Officer

Cheshire and Merseyside Cyber Security Update

1. Purpose of the Report

- 1.1 Following two high profile cyber-attacks which impacted several trusts in Cheshire and Merseyside during December 2024, this paper is intended to update on the nature of those incidents, The initial assessment of impact and emerging lessons learned.
- 1.2 The paper also provides the Board with an update on the programme approach to take forward the recommendations set out in the Cheshire and Merseyside ICS Cyber Security Strategy which was approved at this Board in March 2024. The local incidents came at the end of year which had also seen other significant incidents which impacted the NHS: the Synovis Ransomware attack in June on the shared pathology service run by Guy's and St Thomas' NHS Foundation Trust and King's College Hospitals NHS Trust, which cause extended disruption to organisations across London and beyond :and the CrowdStrike incident in July which although not the result of malicious activity (the company inadvertently applied a faulty software update), caused 8.5 million computers running Microsoft windows to crash worldwide and caused GP Practices and Trusts using EMIS solutions to lose systems for up to 48 hours
- 1.3 The report also highlights funding challenges and the resourcing risk this presents to a successful and timely delivery of the programme.

2. Executive Summary

- 2.1 Cyber Security is defined by the National Audit Office (2024) as, “the activity required to protect an organisation’s data, devices, networks and software from unintended or unauthorised access, change or destruction via the internet or other communications systems or technologies. Effective cyber security relies on people and management of processes as well as technical controls”.
- 2.2 The Cheshire and Merseyside ICS Cyber Security Strategy was approved in March last year and sets out clearly a detailed set of deliverables across 9 overarching themes (Figure One).

Figure One - Strategic Themes

1	Cyber Governance	The C&M ICS leads, drives, and oversees cyber security activities across all ICS partner organisations, underpinned by a clear governance and efficient reporting structures.
2	Cyber Risk Management	The C&M ICS and its partner organisations utilise a standardised approach and digital tools to identify, assess, manage, and mitigate cyber risk to its critical systems and services.
3	Cyber Incident Management	The C&M ICS collaboratively and consistently identifies, responds to, and recovers from cyber security incidents, minimising their impact on critical services, utilising the standardised incident management approaches and ICS-wide SOC capability.
4	IT Procurement	The C&M ICS maximises its use of nationally provisioned tools and services to eliminate procurement duplication and takes advantage of economies of scale, while effectively managing third-party suppliers.
5	Third-Party Risk Management	The C&M ICS uses a risk-based third-party risk management framework to <u>effective</u> manage cyber security risk associated with third-party tools and services, while effectively selecting, contracting, monitoring and off-boarding external service providers.
6	People and Culture	The C&M ICS has a strong cyber security culture, backed by a robust training and awareness programme that communicates and embeds staff's security responsibilities, as well as allows the ICS to detect cyber security knowledge gaps so that staff can be upskilled constantly.
7	Knowledge Sharing and Good Practice	The C&M ICS has a robust cyber security knowledge-sharing culture where all personnel use tools to efficiently exchange and discuss industry good practices, information, and recent cyber activities.
8	Cyber Security Policies and Processes	The C&M ICS manages cyber security across all ICS partner organisations by standardising and improving cyber security policies and processes, as well as identifying and correcting policy non-compliance.
9	Cyber Baseline and Minimum Standards	The C&M ICS supports its partner organisations in upholding robust cyber security and improving cyber resilience by developing and supporting the roll out of minimum cyber security standards across the ecosystem.

2.3 **Cyber Security incidents.** This report summarises the Cyber security incidents that occurred in two provider organisations in late 2024. It describes the impact that they had to clinical services and the learning that has come from these both from a technical and incident management perspective. This learning forms a key part of the proposed “**Vulnerability management plan**” which outlines a significant stepped change in the ICB’s approach to proactively monitoring and managing cyber security standards via the commissioning process. It should be noted that this will not detract from individual organisation’s responsibilities to managing these risks. From an incident management perspective, the key learning is that whilst the root cause of Cyber security incidents may be technical, the impact is to the delivery of patient care and as such needs significant clinical and operational leadership to ensure that any issues are managed safely and effectively.

2.4 **ICB’s responsibilities for Cyber Security.** There are two key aspects to this, firstly the ICB is responsible for cyber risks internally, primarily through the management of IT service providers. However, there are also a significant and challenging set of responsibilities for managing Cyber risks across the system. These are outlined in the report along with updates on progress to date which whilst positive in some areas, is unfortunately limited due to resource constraints.

2.5 **Increase in Direct System Oversight and Assurance.** The evident collective culture and collaborative approach to cyber security has stood the C&M system in good stead to this point and given us an excellent basis to build a comprehensive single approach to this agenda. However, much of the cyber risk assessment and reporting across providers is organisationally self-

assessed and key metrics probably not consistently understood and used for benchmarking and real-time assessment of vulnerability.

- 2.6 Learning from the recent incidents and subsequent detailed advice from the national Cyber Security Leads gives us a clear set of “Good Housekeeping” areas of focus, which if applied rigorously will protect against the efforts of most (although not exclusively) malicious threat actors. For example, we know that nationally a significant number of successful attacks occur where multi-factor authorisation (MFA) is not in place to govern access to systems. So, although slightly inconvenient for users and frustrating to get used to we must be resolute in driving its application across our estate.
- 2.7 The paper signals our intent to increase the assurance focus of our ICB leadership of the system, building (co-design with CIOs) a set of consistent KPIs and metrics which we will then report on (and assure through Audit). On an ongoing basis. This single version of the truth will help us identify and mitigate risk as a system but also allow us to direct funding where it is most need to level up across providers. The data will drive this vulnerability management programme.

3. Ask of the ICB Board and Recommendations

- 3.1 **The Board is asked to:**
- **Note** the update on the two Cyber incidents that occurred in provider organisations in late 2024, along with the learning from these and further actions planned.
 - **Note** the progress against delivery of national Cyber Security Strategy themes acknowledging the impact of withdrawal of national revenue funding.
 - **Approve** the next steps proposed including development of the “**Vulnerability management plan**” which includes improvements to transparency, the ability to hold organisations to account and associated governance.

4. Reasons for Recommendations

- 4.1 The ICB has a responsibility robust effective management of cyber security risk to minimise the impact to the delivery of high quality, safe and effective clinical and care services. Approval of the recommendations above would make significant improvements to this.

5. Background

- 5.1 Cyber security is often seen as a technology issue, and in many ways, it is technical staff who build and monitor the defences and who will work to bring

systems back online after a disruptive event but that’s not where the real impact is felt. Our reliance on digital systems and data is such that our daily clinical and care services cannot operate efficiently or effectively in their absence and means that when there are disruptive events it is patient care and business activities that suffer.

- 5.2 At an ICS-wide level, incidents, like we saw in late 2025, can cause significant disruption to those services which support the delivery of care, and which may ultimately result in sub-optimal care and outcomes. Cyber security is a patient, not technology, risk is the mantra from NHS England.
- 5.3 The role of the ICB. As well as its accountability for ensuring effective cyber security arrangements in respect of its own business systems and data, the ICB has a clear and challenging role as an Operator of Essential Services (under the Network and Information Systems Directive 2018 as well and the Data Security and Protection Toolkit. The Cyber Strategy for Health and Social Care ([A cyber resilient health and adult social care system in England: cyber security strategy to 2030 - GOV.UK](#)) defines a number of accountabilities for ICBs, across the ICS:-

National Strategy Theme	Responsibility
Focus on the greatest risks and harms	<ul style="list-style-type: none"> • Collate/record risks across the ICS • Create, invest in and review ICS-wide mitigation plans • Embed cyber risk in corporate risk planning and reporting • Ensure supplier risk is understood and managed
Defend as one	<ul style="list-style-type: none"> • Create an ICS-wide cyber strategy • Allocate funding for delivery of the strategy • Ensure alignment with agreed security standards across organisations
People and culture	<ul style="list-style-type: none"> • Create an appropriately resourced cyber function • Recruit, train and retain through ICS –level and local resources • Make cyber multi-disciplinary • Share best practice across orgs
Build secure	<ul style="list-style-type: none"> • Build security by design working with suppliers • Engage orgs on compliance with standards • Develop and deliver a cyber security programme with metrics
Response and recovery	<ul style="list-style-type: none"> • Create a central response function • Ensure ICS and local incident rehearsal and improvement • Lead ICS level exercises • Develop central ICS resilience

- 5.4 These accountabilities and responsibilities are at the core of the Cheshire and Merseyside Cyber Security Strategy which was approved by the Board in March 2024. **In summary from a system wide perspective, the ICB is responsible for:**

- Incident management in case of a Cyber security attack in one of its constituent organisations.
- Delivery of the national Cyber Strategy responsibilities outlined above.

6. Cyber Strategy Programme Plan

- 6.1 Mersey Internal Audit's Cyber Team have for several years been commissioned to facilitate system-wide cyber efforts and provide programme management for the Cyber Resilience Programme. Funding for this support has come from national allocations in previous years which has been stretched to cover some limited support into 24/25 and has allowed us to maintain a programme approach.
- 6.2 During 2024/25 Cheshire & Merseyside was notionally allocated revenue funding in two tranches:
- £277k from the Cyber Support fund (which was related to the strategy and advised last March)
 - £622k from a further round of funding confirmed in October allocated from the national Cyber Support Fund.
- 6.3 A proposed programme delivery plan was developed using that funding which would deliver against the key strategy objectives over a 2/3 period.
- 6.4 Unfortunately, we were notified in December that both allocations would **not** now be made available in year due to in-year financial challenges around planned capital to Revenue transfers
- 6.5 A key step change in deliverables which this funding was intended to cover was the initial establishment "centre of Excellence" team which would provide expert leadership and co-ordinate a federated approach across all providers, supporting the teams in Trusts to work in a consistent way and manage risks as a collective.
- 6.6 We have had indications that the national funding may be re-provided in 25/26 but need to contingency plan how we take forward the highest priority work using available local resources. Progress will inevitably be slower without national funding.

7. Progress to date

- 7.1 It should be noted that progress to date has been constrained to some extent by a lack of dedicated resources, however the detail below provides an overview of the progress that has been made in the areas where the ICB has responsibility.

7. Incident management

7.1 From an Incident management perspective, a Digital Incident plan has been developed with significant input and support from Digital and EPRR colleagues across the system. This has been tested during two system wide Cyber security exercises (March and November 2024) and deployment during the incidents in November / December 2024.

8. National Strategy deliverables

National Strategy Theme	Responsibility	Progress to date
Focus on the greatest risks and harms	<ul style="list-style-type: none"> Collate/record risks across the ICS 	<ul style="list-style-type: none"> In the process of collating BAF level risks for all organisations.
	<ul style="list-style-type: none"> Create, invest in and review ICS-wide mitigation plans 	<ul style="list-style-type: none"> Work has started in some areas however needs to develop into a more systematic approach. See proposal in next steps below
	<ul style="list-style-type: none"> Embed cyber risk in corporate risk planning and reporting 	<ul style="list-style-type: none"> Exists in most organisations but further assurance needed.
	<ul style="list-style-type: none"> Ensure supplier risk is understood and managed 	<ul style="list-style-type: none"> Progress to date limited, existing knowledge needs to be aligned and collated and a management plan developed. See proposal in next steps below
Defend as one	<ul style="list-style-type: none"> Create an ICS-wide cyber strategy 	<ul style="list-style-type: none"> Complete and approved by Board in March 2024
	<ul style="list-style-type: none"> Allocate funding for delivery of the strategy 	<ul style="list-style-type: none"> National revenue funding has been withdrawn for 2024/25. However circa £1m capital has been allocated to address cyber risks in individual providers
	<ul style="list-style-type: none"> Ensure alignment with agreed security standards across organisations 	<ul style="list-style-type: none"> Initial baselining work has been carried out, further work proposed in next steps below.
People and culture	<ul style="list-style-type: none"> Create an appropriately resourced cyber function 	<ul style="list-style-type: none"> Progress been constrained by lack of funding.
	<ul style="list-style-type: none"> Recruit, train and retain through ICS –level and local resources 	
	<ul style="list-style-type: none"> Make cyber multi-disciplinary 	<ul style="list-style-type: none"> Work needed with OD support to address this

National Strategy Theme	Responsibility	Progress to date
	<ul style="list-style-type: none"> Share best practice across organisations 	<ul style="list-style-type: none"> Cyber leads meet regularly to discuss challenges and work collaboratively to share solutions.
Build secure	<ul style="list-style-type: none"> Build security by design working with suppliers 	<ul style="list-style-type: none"> Work has started on this with new system wide initiatives such as Cloud based PACS and LIMS. Further work needed to gather more assurance that this is being done systematically.
	<ul style="list-style-type: none"> Engage organisations on compliance with standards 	<ul style="list-style-type: none"> Initial baselining work has been carried out, further work proposed in next steps below.
	<ul style="list-style-type: none"> Develop and deliver a cyber security programme with metrics 	
Response and recovery	<ul style="list-style-type: none"> Create a central response function 	<ul style="list-style-type: none"> Initial discussions have taken place, priority focus for 2025 (see next steps below)
	<ul style="list-style-type: none"> Develop central ICS resilience 	
	<ul style="list-style-type: none"> Ensure ICS and local incident rehearsal and improvement 	<ul style="list-style-type: none"> Two incident exercises completed during 2024 (March and November). Incident plan has been updated to reflect learning during these exercises.
	<ul style="list-style-type: none"> Lead ICS level exercises 	

9. Cyber security incidents at provider organisations in Cheshire and Merseyside

- 9.1 In late 2024, there were two significant cyber incidents within the ICS; one at Wirral University Hospitals NHS FT and the other at Alder Hey Children’s NHS FT and Liverpool Heart and Chest NHS FT (LHCH) via a shared digital infrastructure.
- 9.2 At a high level, the Wirral incident caused the organisation to take their core Electronic Patient Record (EPR) system offline while forensic investigation and remediation took place. This process along with preparations to get the EPR back online took around eight days. The malicious activity was picked up very early in WUHFT with suspicious activity detected on trust servers. This allowed early pre-emptive decisions to be taken by the Trust such as taking their core Cerner EPR offline to remove the threat of infection. This triggered the Trust Business Continuity Processes which inevitably resulted in some patient activity being cancelled and rescheduled. However, this clear and decisive thinking may have saved further clinical disruption and harm in the long run.

- 9.3 The Alder Hey and Liverpool Heart and Chest incident, had significantly less disruption to clinical services with alternative solutions being provided to clinicians in a matter of hours. However data was stolen belonging to patients from LHCH and Liverpool University Hospitals, a small sample of which was published online.
- 9.4 Both incidents were felt more widely than the organisations directly attacked. Whether it was the impact of clinical service disruption upon which multiple Trusts relied, the release of data into the public domain or further disruption cause by suppliers taking defensive action and disconnecting other systems it is clear that the impacts were massive both operationally and reputationally and there was a direct impact on clinical care.
- 9.5 The Cheshire and Merseyside Cyber Incident management plan which has been co-developed during this 2024 by Digital and EPRR colleagues had co-incidentally been tested in a workshop earlier in the month and so was familiar for colleagues to refer to and follow. The plan will be tweaked and enhanced as part of the lessons learned work but was broadly deemed fit for purpose and helpful managing the incident.
- 9.6 The Incidents occurred during a period of extreme pressure in the Unplanned and Emergency Care system and so consequently it was classified as a single level 3 Critical Incident managed through the Regional EPRR team.
- 9.7 Following de-escalation a formal recovery workstream has been established, led by the Regional Director of Digital Transformation. That programme will consider a range of recovery and lessons learned activities against the following categories: Digital; Data & Information; patient Safety; Operational Resilience; Legal & Governance and Finance and Resourcing
- 9.8 Although the two cyber-attacks happened in quick succession and root cause analysis and recovery efforts were managed in parallel, the National colleagues involved in the incident management could see no evidence to connect the two incident and they were felt to be the work of different unconnected threat actors.

10. Impact of Incidents

- 10.1 The recovery programme will formally report on the themes described and the ICB will feed local learning and quantification of impact from C&M Trusts into that process. The final report will give a full account and cost, but we have some indicative estimates available now which illustrate the nature of the impact felt by the organisations involved.
- 10.2 **WUHFT.** In WUHFT for example operation under business continuity processes necessitated a range of patient facing activities to be cancelled. An early estimate (yet to be validated) of the volume of activity and notional cost was:

	Activity	Value
Day Case	1,491	£1,408,503
Elective	181	£811,777
Out Patient First Attendance	2,886	£478,888
Out Patient Follow Up	7,860	£732,976
Out Patient Procedure	258	£74,203
Total	12,675	£3,506,347

10.3 In terms of patient harm, the Trusts' summary position is:

Patient safety incidents were tracked via the command structure and the Trust Risk Management Policy. 109 incidents were logged with reference to the downtime. 106 of these were scored as either Low risk or Very Low Risk. 3 were scored as moderate risk but of those there were no reports of patient harm. The 3 moderate risks pertained to staffing pressures in admissions areas, laboratory delays and risk of prescribing errors.

10.4 **LHCH.** The nature of the incident in Liverpool was different and although some data was lost, services were not significantly disrupted, and systems remained up and running throughout the incident. Initial assessments of impact are:

LHCH Current financial impact:

- costs for rebuild of Citrix gateway
- CCC on call costs in and out of hours (paid by CCC) for technical support
- £36,800 for KMPG forensic analysis of data exfiltrated data to support Trust accountability on guidance on Hill Dicks and recommended action by ICO
- legal costs to support Trust position as above.

Activity impact:

- a number of clinics cancelled 28th and 29th Nov due to Citrix access (other methods adopted thereafter)
- some impact on blood results on 28/11 when firewall taken offline via LUHFT Individual patient impact not quantified at this time.

10.5 **Alder Hey.** Alder Hey and LHCH have shared Digital Infrastructure which is currently supported by a shared digital team hosted at Alder Hey. Although the entry point used by the threat actor in this incident was shared the confirmed loss of data has not included AH patients. The Trust's estimate of cost is in terms of incident management and post incident remediation and the estimate is as follows:

Cyber Costs incurred		
Item	Estimated Cost £	Comments
overtime and on call	4,000	To support with containment and recovery - Estimate
Intercity Professional Services	15,000	Work completed by our outsourced network provider and part of containment - Estimate and still being negotiated
Legal Fees	5,000	Review of our legal position with LHCH.
Total	24,000	

Cyber Costs incurred		
Cyber Recovery Costs		
Item	Estimated costs £	Comments
Coding Recovery	15,000	Remote access being unavailable for a number of days has impacted performance, external support needed to recover
New Citrix environment	10,000	Upgrade Citrix environment to latest supported version
Labcomm unsupported system	40,000	Unsupported system in Labs which needs upgrading to ensure cyber resiliency
Penetration Testing	10,000	Test the new Citrix environment to ensure its secure from a future attack
Total	75,000	

11. Incident Recovery & Learning

11.1 The regional recovery programme will formally capture lessons learned but from a C& M perspective there a number of initial reflections which will inform our thinking and action plan.

- The ICB and Trust response was well coordinated with joint working between Digital, EPRR SCC and On call staff. Incident response Plan was effective.

Further refinements will be made to the plan to clarify split of responsibilities with Regional and national colleagues

- In both incidents there was prompt action from the NHS national Cyber Security Operations Centre (CSOC). They deployed resources immediately and took charge of incident management. CSOC mobilised a range of additional resources to assist including the National Crime Agency, Police, and forensic support through KPMG

As part of the strategy, we have a commitment to develop a local ICS wide core team- scope and scale of that team will reflect the positive experience of the CSOC response. Ongoing dialogue with the NHS Executive Director of National Cyber Security Operations and Regional Digital Team to define respective responsibilities.

- Detailed communications during incident. The instruction from CSOC incident command during the incidents was to limit external discussion of the nature of the attacks even with neighboring Trusts. This policy is intended to avoid emboldening the threat actors or giving any insight into the progress on incident response. It also allows the impacted Trusts to focus on diagnosis and remediation without distraction. However, it did have the understandable effect of incorrect information being shared through a range of informal channels. We also saw third party suppliers taking unilateral decisions to disconnect our Trust from their systems because of uncertainty about their own exposure to risk.

This will be part of the Regional Recovery work. Discussions with the National team are continuing about how to safely share appropriate levels of information with wider stakeholders during an incident without compromising the incident response or any potential criminal prosecutions.

- Experience of both incidents reinforced one of the core criteria in the strategy, that all parts of the ICS must “defend as one”. Trusts often have shared infrastructure, and systems are used by staff in other organisations in this cardiology PACS hosted in LHCH support by AH digital colleagues used by LUHFT staff for delivering their clinics.

An ongoing focus of the programme is to stress this interdependence and recognise we are only as strong as our weakest link. Transparent and supportive sharing of risk and vulnerabilities as a collective is imperative and any national investment should priorities levelling up and supporting those organisations with cyber challenges

- Formal Position on non-payment of ransom – The national position is that “we don't pay ransoms” but we now understand that is advice not policy. Ultimately this is a local decision on a case-by-case basis. It is important to have an unambiguous position on this because it informs the approach to risk and incident management.

It is proposed to work with Regional and National colleagues to get a clearer position and bring a recommendation back for consideration.

- The incident in WUHFT had a disruptive impact but the scale of impact was controlled by the use of a well understood Business Continuity Plan

The importance of BCP planning and regular testing will be a core part of the programme and picked up with EPRR colleagues as part of local lessons learned exercises.

11.2 **Vulnerability Management.** The incidents above **may** have been mitigated if core cyber security standards had been adhered to. The information in the appendices further supports that there are still significant gaps in compliance with basic Cyber security standards in multiple organisations which in turn, lead to vulnerabilities for all organisations because of the interconnected / cross organisational patient flows, clinical services (such as pathology and Imaging) and supporting digital infrastructure and clinical systems. These are just examples however and there are many other technical aspects to Cyber risk that to need be shared, understood and proactively managed in order to manage and mitigate these as effectively as possible.

11.3 Whilst there is significant expertise, professional advice and support available from the National Cyber Security operations centre they rely on staff at a local level to have the in-depth knowledge of local systems and infrastructure to carry investigation and remediation. It is key therefore that resource is identified, and a plan is developed to deliver this, thus protecting the wider system, our patients, staff and their families to the best of our ability.

11.4 Following these incidents based on intelligence obtained through the investigations, a brief survey was completed by each Trust in the ICB setting out their posture against several relevant cyber controls. The questions required binary responses, either a control was in place or was not, organisations where work was in progress were marked as a “no” as the vulnerabilities would continue to exist until such time as the issue was fully addressed. This results are mapped in in the heat map below.

Organisation	Org 1	Org 2	Org 3	Org 4	Org 5	Org 6	Org 7	Org 8	Org 9	Org 10	Org 11	Org 12	Org 13	Org 14	Org 15	Org 16	Org 17
All externally facing firewalls rules have been reviewed and it is confirmed that they are appropriate to business requirements.	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
All remote ingress points into the network that provide remote access services (Citrix, Horizon, VPN technology (Cisco AnyConnect, AOVVPN etc.) have been reviewed and it is confirmed that these are...	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MFA is enabled on all incoming remote sessions (even via HSCN) for the above services.	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Security groups for remote access have been reviewed and it has been confirmed that only appropriate accounts have remote access	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
It has been confirmed that any accounts inactive for over 30 days have been disabled.	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No	Yes	No
All generic accounts have been reviewed and it is confirmed that there is a business justification for these and that these are appropriately secured.	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	No
It has been confirmed that all accounts with elevated permissions (domain admins, local admins etc.) are required and secured with an appropriate privileged access management system.	Yes	Yes	No	No	No	No	No	Yes	No	No	Yes	No	No	No	No	No	Yes
It has been confirmed that logs from authentication engines that are externally facing (multiple failed logins etc.) are streamed into a SIEM/Log monitoring solution which is being actively monit...	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	No	Yes	Yes	No	Yes	No	Yes	No
We have run vulnerability assessments against all externally facing services in the past month and confirm that all critical and high level vulnerabilities that were identified have been resolved.	No	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No
It is confirmed that all file shares have been reviewed to ensure that appropriate permissions are applied.	Yes	Yes	No	No	No	Yes	No	Yes	Yes	Yes	No	No	Yes	No	Yes	No	No
It has been confirmed that all connectivity to other trusts is secured with firewalls	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
It is confirmed that all servers and end user devices are enrolled into MDE telemetry.	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	No
All medical/IoT devices are enrolled into a suitable vulnerability detection/assessment solution	No	Yes	No	No	Yes	No	No	Yes	Yes	No	Yes	No	No	Yes	Yes	Yes	No
Which solution are you using?		Cyrenio			Amis Cyrenio			Cyrenio	Amis		Cyrenio			Cyrenio	Cyrenio	Cyrenio	

11.5 Looking vertically, it can be seen that there are varying degrees of effective control implementation across the ICS with several organisations particularly exposed. Looking horizontally, it is clear that there are a number of common exposures, particularly in respect of:

- the existence of unreviewed generic and stale user accounts.
- the absence of privileged access management systems (note: a number of these organisations have, in the past few weeks, had capital allocations approved by NHSE for the implementation of Solutions).
- access to data shares; and
- the absence of monitoring solutions for internet connected (particularly medical) devices.

11.6 While organisations are working towards addressing these issues several of them require significant resources and/or tooling investment to fully remediate.

12. [Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities](#)

Objective One: Tackling Health Inequalities in access, outcomes and experience

Ensuring Reliable provision of clinical and administrative systems consistently across the ICS is a core requirement. The levelling up ambitions in the cyber programme will help manage consistent availability of system son all places.

Objective Two: Improving Population Health and Healthcare

The Data into Action capability which provide key insight to manage population health relies of consistent data feeds from multiple systems in the constituent organisations of the ICS. Ensuring those systems are cyber secure is a vital part of our governance and oversight.

Objective Three: Enhancing Productivity and Value for Money

Developing a central cyber security function for C&M will enable economies of scale. The opportunities which artificial intelligence and other productivity tools offer will need increase dependence of data and therefore security of underlying systems will become even more critical.

Objective Four: Helping to support broader social and economic development

Digital infrastructure and Clinical systems are key enablers to delivery of all ICB Strategic objectives and priorities.

13. [Link to meeting CQC ICS Themes and Quality Statements](#)

Theme One: Quality and Safety

Managing Cyber security risk is key to enabling the delivery of high quality, safe and effective care. Loss of key clinical and operational systems for any significant period of time can lead to delays in treatment, and sub optimal decision-making due gaps in patient data

Theme Two: Integration

A coherent, interoperable landscape of systems which share data effectively to support patients wherever they come in contact with services is a key underpinning enabler of integrated care. The development of large shared systems such as PACS imaging and pathology increase the opportunities for system integration but also increase the risk of disruption in the event of a cyber-attack. It is therefore critical that the management of cyber security at system level is given high priority.

Theme Three: Leadership

The ICB has significant clearly defined responsibilities around leading the strategic development of Cyber Security standards across all its constituent organisations.

14. Risks

- 14.1 This paper refers to the BAF risk P11 and proposed actions form a key part of mitigation of this risk. Associated key risks outlined in this paper include:
- Lack of dedicated resources to deliver the ICB’s responsibilities defined in the national and ICS strategy.
 - Lack of dedicated resources to lead and manage Cyber security incidents 365 X 24/7. This is currently done on a best endeavours basis.
 - The evolving nature of cyber security means that new risks emerge requiring an adaptive approach to management and mitigation.
- 14.2 Funding and limited Resources are the biggest barrier to progress in this area. Key posts in the ICB digital team have never been filled due to the overarching financial position and vacancy freeze. Leadership across the system relies on support from MIAA and Provider CIOs “leaning in” and providing subject-matter expertise and national funding is unpredictable and often capital only which makes it difficult to develop the necessary core capabilities. This represents a priority area for recruitment if financial controls allow and the creation of a system-wide cyber team must be a priority. We need to build an investment case that doesn’t not rely on national funding allocations.

15. Finance

- 15.1 National cyber security revenue funding for 2024/25 was withdrawn because of the financial position of the NHS. A limited amount (circa £1.2m) of capital funding was allocated to provider organisations to address key technical risks. The funding position for 2025/26 is not currently clear.

16. Next Steps and Responsible Person to take forward.

- 16.1 **Cyber Incident Recovery.** In terms of the Cyber incidents, NHS England NW are leading a Recovery and Restoration strategy with the following aim: -

“It is the intention of the NHS England North West (NHSE NW) to ensure NHS organisations recover from the impact of two recent cyber incidents and coordinate the recovery of procedures systems and processes to ensure the ongoing safe delivery of patient care. Ensure strategic recovery from the cyber events(s) is in a way that protects and saves life, reduces humanitarian suffering and is compatible with the vision and values of the NHS. Any actions taken in the recovery phase reflect and comply with Statute, NHS Instructions, NHSE Policies/Procedures and any recognised non-statutory guidance and best practice.”

- 16.2 The process will include workstreams to focus on Patient Safety; EPRR; Legal and Governance; Data and Information; Finance and Resourcing and Digital.
- 16.3 **ICB responsibilities for Cyber Security.** In order to ensure we are discharging our responsibilities as an ICB to the best of our ability and learn from the incidents in late 2024, it is proposed that we develop and implement to address gaps in national strategy responsibilities via a **Cyber Security Vulnerability Management plan** which will include:
1. Collation of all Cyber related risks (both system wide and organisation level) into a system wide risk register with associated mitigation plans.
 2. Define best practice standards (to be agreed by likely to include standards in exercise described on page 8) these will be included in provider contracts via the commissioning process. A systematic and transparent process to monitor these will be established and will include a right to audit where standards are monitored via self-assessment.
Please note - From an ICB perspective this will also include services provided by the three IT providers.
 3. Continue ongoing dialogue to determine the appropriate level of resource and expertise needed to monitor and support organisations at a local in collaboration with and support of the national Cyber Security operations centre. This resource would be diverted to assist with investigation and remediation during any future incidents.
 4. Supplier management - existing knowledge needs to be aligned and collated and an action plan developed to ensure vulnerabilities are being managed collectively where appropriate.
 5. "Security by design" to be built into all Digital programmes via the appropriate governance.
 6. Continue with system wide Cyber incident exercises every 6 months in order to both test the Digital Incident plan, explore evolving scenarios and ensure readiness for an incident scenario.
 7. Strengthen existing Cyber Security Governance oversee delivery of the actions above, holding organisations to account to ensure actions are taken.

17. Officer contact details for more information

John Llewellyn, Chief Digital Information Officer

Meeting of the Board of NHS Cheshire and Merseyside

30 January 2025

Data Into Action - Progress update

Agenda Item No: ICB/01/25/24

Responsible Director: Prof. Rowan Pritchard Jones
Medical Director

Data Into Action - Progress update

1. Purpose of the Report

- 1.1 In April 2024 the ICB Board agreed to formalise the Data Into Action Programme and requested it reported directly to the Board twice a year. This presentation provides an update to the Board to raise awareness of the work and focusses on the following aspects of the Programme:
- The prioritisation process to identify the pieces of evidence-based work that have been assessed to have the biggest impact across the ICS (scalability, outcomes, efficiency gains) and the progress achieved to date.
 - The work related to public and patient engagement on the use of data
 - The impact of the Population Health Academy in developing workforce capability
 - Partnerships with academia and the development of the research platform infrastructure (Secure Data Environment (SDE))
 - Developing the evidence base for strategic commissioning supported by the opportunity offered through the selection of CM ICB as a national incubator for the Federated Data platform (FDP) population health management product.

2. Executive Summary

- 2.1 **National Context.** The national policy direction supporting a programme such as Data Into Action is influenced by the Darzi review that identifies strategies to utilise data for a sustainable shift in healthcare allocation. This shift moves from funding based on activity ("see and treat") to funding based on targeted needs ("predict and prevent"). Commonly known as population health management, this approach demonstrates how it is possible to significantly reduce the demand for health and social care services by better understanding needs, improving patient services, and breaking the cycle of rising costs. This method, already proven effective at scale in multiple integrated care systems across England, combines data and artificial intelligence (AI) at a local level to support the transformation of patient pathways. It aims to radically improve outcomes, increase efficiency, and enable evidence-based reallocation of resources to primary, secondary, and tertiary prevention.
- 2.2 **Cheshire and Merseyside context.** Within Cheshire and Merseyside, the Data Into Action Programme has successfully embedded a population health approach, which is now considered exemplary by NHS England. This bottom-up transformation is well-supported by local clinicians and care systems through a multi-professional steering group. It is also backed by the public and patients, as evidenced by the outputs and reports from the Patient and Public Involvement and Engagement (PPIE) work.
- 2.3 The programme includes a Population Health Academy to build capability in data usage among the workforces. Additionally, the data resource for the



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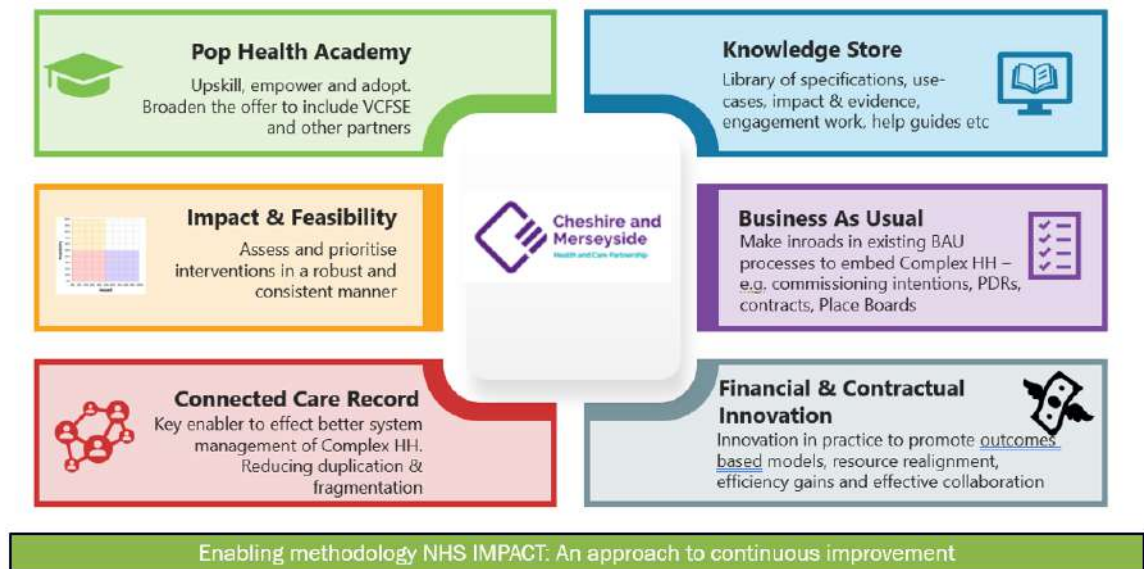


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Integrated Care Board (ICB) is an asset for the North West Secure Data Environment, providing researchers with access to high-quality, well-curated data sources.

2.4 The development of this robust data infrastructure and its demonstrated impact on outcomes and efficiency has led NHS England to select Cheshire and Merseyside Integrated Care System (ICS) as an incubator for the development of an ICS Federated Data Platform (FDP) Population Health Management product. Collaboration with the FDP team will enhance existing capabilities, supporting a comprehensive health economics approach to strategic commissioning and providing an evidence base for the "left shift" in healthcare.

2.5 Further to the Strategic Leadership Forum session December 2024, six key enabling actions were identified to support strategic commissioning through the lens of the complex household's segment of the population. These are:



3. Ask of the Board and Recommendations

3.1 The Board is asked to:

- Note the content of the presentation and the progress being made in supporting the objectives of the ICB
- Mandate an accountability framework to support an approach to strategic commissioning that ensures that the ICB scale and embed DIA priorities and products by:
 - Creating an appropriate governance at Place to ensure that DIA proactive models of care are designed and mobilised as part of a wider Community approach
 - Embedding the six key enabling actions for Complex Households

4. Background

- 4.1 In April 2024 the programme was formally established by the ICB Board. The Board asked for this programme to report directly to the Board twice a year.
- 4.2 Outside of this arrangement the programme reports progress through its own Programme Board and to; Population Health Board; Digital Transformation and Clinical Innovation Board; Clinical Informatics Advisory Group; Transformation Committee (on request); and externally to the University of Liverpool Civic Health Innovation Lab (CHIL) stakeholder Board.
- 4.3 The programme and its activities continue to be well received and consistently supported.

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

Objective One: Tackling Health Inequalities in access, outcomes and experience

The Population Health Management deliverables and products that DIA has created to date and are in the future pipeline, enable an intelligence led approach to targeting the most vulnerable cohorts of the population. These draw upon a range of factors such as deprivation, age, gender, ethnicity and unequal access to services and allow end users to interrogate multifaceted datasets to explore solutions to addressing root causes

Objective Two: Improving Population Health and Healthcare

The correlation of a range of interventions to improving population outcomes is central to the research component within DIA and will be instrumental in helping to determine the best return of investment when assessing the potential interventions for improving life expectancy, quality of life and experience. Inequity in the provision of appropriate interventions, either through different models of care, timeliness of support or integration with other clinical or broader determinants services can be effectively analysed using the linked dataset. This in turn can be used for strategic planning and service redesign purposes.

Objective Three: Enhancing Productivity and Value for Money

Within DIA we can assess the level of fragmentation and duplication that exists both within and across different sectors across health and care provision. The scope of this will expand over time as broader datasets are onboarded into the central platform. However, even based on the current scope, the opportunity to streamline, integrate and decommission parts of the C&M system, is considerable.

Objective Four: Helping to support broader social and economic development

The DIA Programme will help to demonstrate to external funding agencies that the C&M system is a place which has the governance and experience to



optimise large research grants and intelligence infrastructure investments. These investments will have a direct link to changing the health and care landscape, configuration of services, system financial planning and population outcomes and as such will be an attractive proposition to a range of external stakeholders/investors.

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

- 6.1 The DIA Programme has the potential to align with all of the objectives within the Annual Delivery Plan. The prioritisation of products/dashboards and the approach to an evidence base for strategic commissioning are being incorporated into the ICB strategic intentions. The programme clearly links to the population health and partnership working for the benefit of our population objectives. It also touches upon others such as diabetes and children and young people, but we expect the reach to increase with the new governance arrangements that positions the programme in the Medical Directorate and in the portfolio of the Chief Digital Information Officer.

7. Risks

- 7.1 There were a number of risks on the DIA Programme risk register in quarter two of 2024/5, but these have now been resolved through action taken by ICB executives and the Finance Investment & Resources Committee. These risks related to the funding of the programme and its formalisation within corporate structures. A full-time Programme Director is now in place reporting to the Chief Digital & Information Officer.
- 7.2 These actions contribute to addressing the corporate digital risk 'P11: The ICB is unable to address inadequacies in the digital infrastructure and related resources leading to disruption of key clinical systems and the delivery of high quality, safe and effective health and care services across Cheshire and Merseyside'. The Data Into Action Programme uses the digital infrastructure to improve the effectiveness of health and care services, by identifying and supporting vulnerable cohorts of the population. This work can now be expanded upon now that there is certainty around programme resources.

8. Finance

- 8.1 The finance considerations relate to the resourcing and operational budget for the programme, and these will be addressed in a paper to ICB Finance and Investment Resources Committee in January 2025.

9. Communication and Engagement

- 9.1 Work has been underway since September 2023 to develop communications collateral for the use of data and the development of a secure data environment to support research. This work has been targeted at both data controllers across CM and also with patients and the public. A number of deliberative events have taken place, and presentations have been made for the public to gauge their understanding of the use of their health and care data and to seek their views. A Public and Patient Advisory Group (PPAG) has been established to formally consider data related issues arising from the overall DIA agenda. As part of this, DIA will be providing a public telephone contact line for anyone wishing to opt their data out of any research or health care interventions informed by linked data.
- 9.2 There is also a raft of engagement work underway via the University of Liverpool Civic Data Cooperative. There are a range of patient and public networks already established which feed into the design of research projects and health and care interventions.
- 9.3 DIA has also created a website where local stakeholders can access clear information on what data is available, how they can access it, what it is being used for and the insight and value that this brings. The website contains a full report of the public engagement forums.

10. Equality, Diversity and Inclusion

- 10.1 An Equality Impact Assessment (EIA) has been developed to understand the breakdown of the population to have insight on the underrepresented groups that would benefit from being part of the wider public awareness on the use of data. This has guided the selection and attention given to developing the public forums and deliberative events. Additionally, through the digital programme extensive work has been conducted through Places on digital exclusion

11. Climate Change / Sustainability

- 11.1 Consistent with United Nations Sustainable Development Goals the programme endeavours to ensure that Goal 3 – Ensure healthy lives and promote well-being for all at all ages – is a principle of the work undertaken through the programme. Of particular resonance through the segmentation work is the need to safeguard the health of ‘vulnerable population groups and individuals living in areas burdened by high disease prevalence’

12. Next Steps and Responsible Person to take forward

- 12.1 A paper was received by the ICB Finance and Investment Resources Committee in January 2025 to consider future resourcing of the data infrastructure for the ICB beyond April 2025 and if approved to secure an operational budget for the DIA programme. A Programme Director was

substantively brought into role in January 2025 to take the programme forward supported in an advisory capacity through a Senior Responsible Officer (SRO)

13. Officer contact details for more information

- 13.1 Data Into Programme Director, Andrea Astbury,
andrea.astbury@cheshireandmerseyside.nhs.uk

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

Held in - Conference Rooms, Riverside Innovation Centre, 1 Castle Drive, Chester, CH1 1SL

Thursday 28th November 2024
09:00 – 13:25

Unconfirmed Draft Minutes

Recording available at: [NHS Cheshire and Merseyside Integrated Care Board – 28th November 2024](#)

ATTENDANCE	
Name	Role
Members	
Raj Jain	Chair, Cheshire & Merseyside ICB (voting member)
Graham Urwin	Chief Executive, Cheshire & Merseyside ICB (voting member)
Claire Wilson	Executive Director of Finance, Cheshire & Merseyside ICB (voting member)
Christine Douglas, MBE	Executive Director of Nursing and Care, Cheshire & Merseyside ICB (voting member)
Prof. Rowan Pritchard-Jones	Medical Director, Cheshire & Merseyside ICB (voting member)
Neil Large, MBE	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Ann Marr, OBE	Partner Member (NHS Trust) (voting member)
Prof. Steven Broomhead, MBE	Partner Member (Local Authority) (voting member)
Dr Ruth Hussey, CB, OBE, DL	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Tony Foy	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Prof. Hilary Garratt, CBE	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Adam Irvine	Partner Member (Primary Care) (voting member)
Dr Naomi Rankin	Partner Member (Primary Care) (voting member)
Andrew Lewis	Partner Member (Local Authority) (voting member)
Trish Bennett	Partner Member (NHS Trust) (voting member)
Erica Morriss	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Warren Escadale	Partner Member (VCFSE) (voting member)
In Attendance	
Dr Fiona Lemmens	Deputy Medical Director, Cheshire & Merseyside ICB (Regular Participant)
Anthony Middleton	Director of Performance and Planning, Cheshire & Merseyside ICB (Regular Participant)
Christine Samosa	Chief People Officer, Cheshire & Merseyside ICB (Regular Participant)
Clare Watson	Assistant Chief Executive, Cheshire & Merseyside ICB (Regular Participant)
John Llewellyn	Chief Digital Information Officer, Cheshire & Merseyside ICB (Regular Participant)
Prof. Ian Ashworth	Director of Population Health, Cheshire & Merseyside ICB (Regular Participant)
Louise Barry	Chief Executive, Healthwatch Cheshire

Professor Paul Kingston	Lead Chair of Research Committee, University of Chester
Laura Marsh	Cheshire West Place Director, Cheshire and Merseyside ICB
Simon Banks	Wirral Place Director, Cheshire and Merseyside ICB
Chris Lees	Associate Director of Primary Care, Cheshire and Merseyside ICB
Jonathan Griffiths	Associate Medical Director of Primary Care, Cheshire and Merseyside ICB.
Claire Haden	Clinical Director, Mental Health Complex Care
Dr Chris Pritchard	Primary Care Clinical Lead for Mental Health
Jennie Williams	(Board Administrator) Senior Executive Assistant, Cheshire & Merseyside ICB

Apologies

Name	Role
Rev Canon Dr Ellen Loudon	Vice Chair, Cheshire and Merseyside Health and Care Partnership

Agenda Item, Discussion, Outcomes and Action Points

Preliminary Business

ICB/11/24/01 - Welcome, Apologies and Confirmation of Quoracy

All present were welcomed to the meeting and advised that this was a meeting held in public. The meeting was declared quorate. Apologies for absence were noted as above.

ICB/11/24/02 - Declarations of Interest

There were no declarations of interest made by Members that would materially or adversely impact matters requiring discussion and decision within the listed agenda items.

ICB/011/24/03 – Experience and Achievement Story

The Board were shown a video on young carers.

Leadership Reports

ICB/11/24/04 - Report of the ICB Chief Executive

The Chief Executive highlighted to the Board –

- Thanks were placed on record to The Chief People Officer who is retiring, and the Executive Director of Finance who is moving to a role in Manchester, for their service to the ICB. Mike Gibney will be joining in January 2025 as Chief People Officer and Mark Bakewell will be taking on the role of Chief Finance Officer for an interim period.
- The Secretary of State met staff who were involved in the Southport incident. The Secretary of State wrote a letter of thanks to the ICB and also wrote to Alder Hey, Mid Mersey and West Lancashire Trust and North West Ambulance Service to pay similar tribute.
- Ten-year plan and commissioning intentions – often experienced in the NHS is the level of dissonance between the time a political announcement has been made and the work that is to be undertaken to enact the consequences, and the dissonance between what is told about public finances and what it means to the NHS. Pay disputes have been settled with no industrial action going into winter. Taxes were raised to pay for the NHS. The NHS will face a significant cost consequence for the added employers national insurance, which is expected to be in the additional funding settlement from the government. There will be little extra money for service development in the coming year. Previous labour governments have invested heavily in the NHS, however this was in the third or fourth year of government. The ten-year plan will be published in May 2025 and will set out how the government foresee a neighbourhood model of health and how investing outside of the hospital will reduce the



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demand on hospitals. Two pieces of work will commence investing in community services, with comprehensive mapping of the current community services to identify the differences that exist. Local authorities will identify neighbourhoods on a specific geographic basis and the NHS will define their neighbourhoods in a different way, a piece of work will be undertaken to understand the dissonance between the two. Community assets and voluntary sector assets will be mapped. The joint forward plan looks into the future which will need to be broken down into shorter chunks. All NHS providers have been contacted to advise what the expected commissioning intentions will look like for next year, consistent with the joint forward plan. If there are any growth monies, this should be directed away from hospitals focusing on areas that change the pressure that exists within hospitals. The allocation for next year is expected from the Department of Health before Christmas.

- Lung health check programme has helped identify cancers in the most deprived areas earlier, and has taken Cheshire and Merseyside above the national average for the early detection of cancer. Tribute was paid to all who work in that field.
- Right care Right Person is a national initiative designed to ensure that people of all ages who have health and social care needs, more principally mental health needs, receive the right support. This is a police led initiative by Cheshire Constabulary and Merseyside Police who have established a strategic and tactical group to implement gradually. The three mental health providers, MerseyCare, Alder Hey and Cheshire and Wirral Partnership Trust are engaged with this piece of work. Local authorities are involved by providing Advanced Mental Health Practitioners who support the sectioning of a person. The voluntary sector provide crisis responses and support the community services. Phase one is now in place and the impact is being evaluated. Phase two has gone live in Cheshire and will go live in Merseyside this week. Phase three pertains to the powers of the police to enter a property under Section 135 of the Mental Health and convey to a health-based place of safety under Section 136 of the Mental Health Act. Police cells are no longer used as health-based places of safety under the Mental Health Act.
- Wirral University Hospital Trust cyber-attack – is still a live incident and is being managed by national cyber leadership. Detail of the malware will not be shared until there is a definitive root cause. Suspicious activity was noted on 25th November 2024 by the digital team at the Trust through monitoring equipment; the national cyber security team were contacted and the impacted machines were isolated immediately. Proactive decisions were made to take clinical systems off-line. Cyber security threats continue to grow, disaster recovery and business continuity plans are important.

The Board Discussed –

- It would be useful to have a report on the learning from the Wirral incident and a cyber security strategy update for the whole system.
- Further thanks were placed on record to The Chief People Officer and Executive Director of Finance for all of their hard work, especially to the Chief People Officer for her work with carers.
- Right person right care - is opening risks to the workforce not seen before. Is being an exemplar of good practice and partnership working across the region.
- Definition of neighbourhoods and the integration with the community and local government is critical. The ICB will not impose boundaries and lines across Cheshire and Merseyside and will work in partnership.
- Health and work was published by the government on 27th November 2024 which is an opportunity for joined up public services to support those on the margins of the labour market who want to work, with additional support. Liverpool City Region was not an area identified as a pathfinder. A clear narrative has been received from the Secretary of State about the opportunities to improve the health of those working and those who step away from work due to health problems.
- Welcoming the decision to pause the review of the operating model work in the nine places and developing strategic commissioning framework. It is important to take into account the roles of local authorities in social care and the roles of health and wellbeing boards in developing a strategic commissioning plan.



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- Medical physicist to improve the use of scanning equipment in Cheshire and Merseyside – celebrating the work undertaken by the cancer alliance.
- Staff vaccination uptake – a view through a national database is received which gives data to review progress. It was noted that the vaccination uptake numbers are low for the time of year.
- Congratulations to employee and team of the quarter – Tim Thompson from the Communications and Engagement team won employee of the quarter, and The Dynamic Support Team from Liverpool place won team of the quarter.

Actions -

- **Anthony Middleton to circulate staff vaccination uptake figures with comparative data, with a breakdown of covid and flu vaccinations.**

The Board Resolved to -

- **Consider the updates to Board and sought further clarification and details.**
- **Disseminate and cascade key messages and information as appropriate.**

ICB/11/24/05 - Report of the ICB Director of Nursing and Care

The Director of Nursing and Care provided an update to the Board highlighting –

- A children and young people's showcase event was held on 11th November 2024 as a part of the North West regional NHS England oversight group. The event was chaired and facilitated by a young person called Izzy who reflected on her experiences of health services across a period of transition between children and adult services. Izzy is part of a group of young people involved in a group and influence campaign which is hosted by the Beyond transformation programme.
- White ribbon day is recognised around the world on 25th November and is the start of sixteen days of action against domestic violence and abuse. The campaign encourages people to take action and change the behaviour and culture that leads to gender-based violence against women and young girls. Within the ICB a culture has been established that supports a workforce that is affected by domestic abuse.
- In November 2024 the Quality and Performance Committee received a paper regarding the rates of health care associated infection within NHS providers and wider place-based systems. The report demonstrated the analytical differences between the delivery of Trusts specific national threshold for health care associated infections benchmarked against the North West and England rates. Seven of the twelve NHS acute trusts have already breached their predetermined thresholds in at least one recorded health care associated infection at month six. The committee were assured of the work being undertaken by the ICB and supported by NHS England to undertake a review of the improvement work within both Liverpool University Teaching Hospitals and Wirral Place.
- The Quality and performance committee also received an update on the progress and assurance against antimicrobial resistance using the NHS system oversight framework.
- Urgent and emergency care – senior clinicians including Directors of Nursing and Medical Directors have been involved in ongoing patient safety work, ensuring that guidance related to maintaining patient safety for those who experience long waits in non-clinical areas continues to be embedded.

The Board Discussed –

- Health Care Associated Infection – quality improvement work is being undertaken with a number of organisations across Cheshire and Merseyside, linking in with the North West, to introduce quality improvement science. There are a number of workstreams and task and finish groups within the two identified organisations who are being brought together.
- The UK Health Security Agency have reported that in the first quarter of this year nationally there has been an 18% rise in c.difficile across the country. Patients are sadly being cared for in sub-optimal environments in hospitals.
- Urgent and emergency care – Healthwatch in Cheshire have attended the Countess of Chester Hospital to undertake a three-day A&E watch. Macclesfield and Leighton A&E watches will also be undertaken. The redlines toolkit is being used as a part of A&E watch and patients receiving care are asked to take



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part in surveys. Any breaches of the redline toolkit during A&E watch visits should be reported to the relevant Directors of Nursing.

- Domestic abuse – the Board fully supports the campaign, last year 53,000 cases of domestic abuse were reported to the police in Cheshire and Merseyside and 38 were people whose cases were subject to domestic homicide review. One in four NHS staff are subject to domestic abuse on a regular basis. Making space for male perpetrators of domestic violence in employment environments so that they can talk and support their rehabilitation. Both Cheshire and Merseyside constabularies have a strategic priority of tackling violence against women and girls, NHS staff are embedded in the governance and process work being undertaken which can be incorporated into the feedback brought to a future meeting.

Actions –

- **The Director of Nursing to provide the Board with an update on the progress made to reduce risk factors of domestic abuse for staff, in twelve months' time.**

The Board -

Noted the updates as outlined within the report.

ICB/11/24/06 - NHS Cheshire and Merseyside Finance Report Month 6

The Executive Director of Finance provided an update to the Board to the end of month six for the whole system 2024 and an update on the very latest position, and highlighted the following key areas –

- Adverse variance against plan as a system, the agreed plan at the beginning of the year with NHS England was a deficit of £150m. At month 6 the ICB are reporting a deficit of £183m against a predicted £134m, meaning almost £50m adrift. A significant amount of work will need to be undertaken with the plans already in place, which accelerate towards the end of the year on cost improvement programmes across all organisations in the system.
- A considerable amount of work was undertaken in the summer across the system to look at the impact of the efficiency programmes and further mitigations for all sixteen organisations plus the ICB, the results of the risk adjusted forecast are updated monthly. An upturn in run rate is expected, closer to the agreed plan.
- Work will be undertaken on elective recovery towards the end of the year, opening up new capacity to generate more income for the system for the Elective Recovery Fund. £5.9m will support the position which we did not have at the beginning of the year, but will have towards the end of the year. A greater step up of the cost delivery programme is expected across all organisations towards the end of the year as plans mature.
- There are a number of individual transactions that will only happen in month twelve within some of the provider organisations; some commercial opportunities of a very large value are being discussed with some providers. Some transactions are not without risk and may slip into the following year.
- The pay award was recently announced and paid this month; funding was received from NHS England to support the costs. The pay award was £13m pressure over and above plan for the year, as the funding received has not covered the full cost. Conversations with providers to understand gaps are ongoing.
- There is a gap of a risk adjusted forecast outturn of £73m.
- To track improvement and to provide the Board with assurance, the ICB Chief Executive chairs a weekly meeting with the chief executives of the organisations with the highest risks to delivery, who present the latest weeks position. Recruitment, overtime, agency and cost improvement programmes are tracked to identify mitigations where needed.
- Providers have a deficit plan for the year of £212m currently, their risk adjusted forecast is there will be a deficit of £254m, with a £42m variance. The ICB set itself a challenging plan to deliver a surplus of £62m which was a result of holding investment and other areas of slippage in order to support the provider position. This is short by £32m, which is a gap against a surplus position.
- Conversations are ongoing daily across provider organisations. There are technical opportunities thinking about the management of capital and revenue budgets together, for opportunities to improve the revenue financial position if there is more capital funding available. Conversations with NHS



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England are taking place to see if there are opportunities for this, which could potentially identify £8m worth of improvement which would support the gap.

- Phase two of the intervention and investigation regime is now underway, which was initiated by NHS England in the summer. Interventions have been put in place for four providers to provide additional support to look for efficiencies to deliver their plans. Support is being sought for the ICB's continuing health care programme, which is making good progress. The phase two impact could be between approximately £6 - £8m.
- Planned investments between now and the end of the year are to be reviewed to see if they are affordable, and the possible consequences of delaying in March / April 2025.
- There are two areas of spend that the ICB can control in-year which are continuing health care and prescribing. There is a £49m forecast overspend in continuing health care and mental health packages and a £23m overspend in prescribing. The £72m pressure is creating the gap for the ICB. There is a myriad of mitigations to support the position, totalling £40m, with £32m not covered as yet. The only way to improve the ICB position is to further address continuing health care and prescribing over and above recovery plans. Additional support has been commissioned in all age continuing health care and work is underway with NHS England to get external scrutiny on prescribing expenditure. This will still mean that the system is £50m away from gap, meaning the deficit for the year will be just under £200m, opposed to the £150m agreed, of which £13m is due to the pay award.

The Board Discussed –

- Cash has been received to off-set the deficit of £150m, this will be shown in future reports. This is much needed cash going out to providers. There are business rules within the NHS where deficits at a system level have to be repaid to NHS England, the deficit that we reported last year will have to be repaid next year, and the deficit we are reporting this year will need to be repaid in two years' time. This is repayable two years after the deficit occurs, capped at a certain percentage of overall turnover. The NHS as a whole has agreed with the treasury a break-even plan, however there are underspends nationally which are offsetting the overspends in budgets at system level. The challenge is there is no more support at a national level to off-set any departure from plan.
- The ICB are in a worse position at month seven than at month six in terms of out-turn. The ICB will miss the plan but will hit statutory duties, Trusts will miss the plan and statutory duties. The consequences of in year actions on future years will need to be understood.
- Do Trust Boards take responsibility for just hitting the deficit control total or their longer-term sustainability solutions.
- The January Board meeting will be used to discuss the overall financial strategy to return to a balanced or surplus position, the controls and mechanisms that will need to be in place and the impact of the continuing deficits in terms of future years funding.

The Board -

- Noted and commented on the financial position and metrics reported at Month 6 and the risks to delivery of the financial plan which were described in the paper.

ICB/11/24/07 – Highlight Report of the Finance, Investment and Resources Committee

The Chair of the Finance, Investment and Resources Committee (FIRC) provided an update to the board highlighting -

- A personal thank you from the Chair of the Finance Investment and Resource Committee to the Director of Finance.
- Grip and control – workforce have a weekly financial incident command meeting chaired by the ICB Chief Executive. This covers substantive, bank and agency and reports across the trusts and is now proactively supported by Chief People Officers across the system. There is progress across agency, with more work to do with bank and substantive.
- CHC and the importance of budget is also included within the financial incident. The efficiencies that are needed to be made are in the bi-monthly recovery committee that scrutinise efficiencies; this will be due back to FIRC for discussion at December's meeting.
- Medicine – PWC did their investigation where it was felt that it would be best left with the ICB for intervention. The efficiency pathway is clear, the challenge is around the resource.



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- Delivery and speed – there is now laser focus on the delivery of efficiencies. PWC phase two will drive this and support with weekly commands. Performance of phase two has been scoped and detailed and will go to FIRC to start in December 2024.
- Pressure on cash within organisations – the majority of the acute trusts are forecasting that they will need cash, meaning a negative impact on the better payment practice. The impact this has on the local economy is delaying payment out to society.

**The Board –
Noted to content of the report.**

ICB/11/24/08 – NHS Cheshire and Merseyside Integrated Performance Report

The Director of Performance and Planning provided the Board with an overview of the integrated performance report focussing on -

- Urgent and Emergency Care – parts of the system have featured at the highest level of escalation in comparison to other systems nationally. There has been a sharp decline in ambulance response times during October and continuing into November, which corresponds across to bed occupancy, long waits in emergency departments, high non-criteria to reside rates and exacerbated by infection prevention control bed closures.
- Where virtual ward capacity is maximised in one geography of provision, boundaries are allowed to be relaxed to make use of overall capacity. There is no additional capacity, it is about making use of the capacity available.
- Work in being undertaken with North West Ambulance Service to avoid conveyance wherever possible. A pilot is starting in Liverpool which will allow ambulance crews who are onsite at home with a patient but where a referral has been made to a community service to leave the patient.
- There are superMaDE events and campaigns home for Christmas taking place.
- The focus is on system governance at a locality basis with a clear way of managing the system on a daily basis, with meetings daily to try to manage the load. One or two of the systems are stepping up an increased battle rhythm.
- Clinical cells have been established, with scrutiny from NHS England.
- Elective – at the end of September there were 985 over 65 week waits. It was the original operational planning intention to eliminate over 65-week waiters by the end of September, recognising the result of industrial action has had an impact on timeframe which has slipped back to December 2024. There are over 20,000 patients waiting in excess of that waiting time nationally. CMAST and providers are working to reduce waiting list size.
- Following last month's board decision to accelerate the reduction of long waiting times and return to the RTT constitutional standards for children and young people, Trusts have been mobilising and have been assessing by speciality and organisation, details of which will be fed back to the January 2025 Board meeting.
- It has been a year since the Board received the integrated performance report; comments have been received on the content which needs to be enhanced. From the Quality and Performance committee, fifteen further metrics have been approved and will feature in board reports from January 2025 using SMART methodology

The Board Discussed –

- Reducing ambulance delays and the challenges faced – the ICB have asked North West Ambulance Service Area Director to lead the improvement programme for ambulances and their ability to respond, not just what happens when an ambulance arrives at hospital to manage crew behaviour to ensure they access services before conveyance.
- Gynaecology waiting lists are a significant national issue with pressures in cancer diagnosis in gynaecology. The government have made a manifesto commitment that all waiting times should be back to a certain point within the life of the first parliament. This has been mapped against all waiting lists and Cheshire and Merseyside can achieve this for orthopaedics. Gynaecology waits have been identified as an area of concern and a significant transformation project will be launched. This is an



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example of inequality which will be addressed. Colleagues from Liverpool Women's Hospital are now going out and co-locating within primary care networks to see patients and train up local clinicians.

Action -

- **The Director of Performance and planning to look at the data that is broken down through an equality lens to understand the experiences of people with protected characteristics, for regular reporting back to Board.**

The Board –

- **Noted the contents of the report and took assurance on the actions contained.**

ICB/11/24/09 – Highlight Report of the Chair of the ICB Quality and Performance Committee

The Chair of the ICB Quality and Performance Committee provided an update to the board, highlighting that the committee looked in detail at health care acquired infection and antimicrobial resistance. The committee focused on hydration and received a report that the national hydration project, which is a training programme for care home staff, began in 2024 and has had significant results with a 40% reduction in Sefton place and nearly 20% reduction in Wirral for hospital admissions for urinary tract infections. This is a preventative approach reaching out to areas other than the hospital setting.

Pilot work is now complete for safety in Halton and Warrington to implement the learning from patient safety events as a replacement to previous reporting systems within primary care. The roll out will inform next steps for improved reporting of patient safety.

The Board Discussed –

- Work the ICB are undertaking to ensure the people with learning disabilities and or autism who are placed in residential settings or receiving high quality care; long terms prevents the breakdown of placements. Merseycare are seeing the results of the work.

The Board noted the content of the report.
ICB/11/24/10 – Consolidated Report of the ICB Place Directors

The Wirral and Cheshire East Place Directors provided an update to Board members which gave an overview of key areas of focus and delivery being undertaken at Place within the Integrated Care System which included –

- Continued place support around patient discharge and flow with a focus on patients with physical and mental health needs moving patients who are clinically ready for discharge in mental health inpatient beds. Home first approach being promoted in physical health settings.
- Significant work being undertaken across place to improve the lives of and to support children and young people, particularly those with complex needs. Work is being undertaken on neurodiversity and understanding the needs of children with ADHD / autistic spectrum disorder and also those who have complex requirements that do not have a diagnosis.
- There is a focus in Cheshire East and West for 25/26 on the population health data to identify particular cohorts of patients that we can intervene more proactively with to reduce health inequalities. Place are thinking at a neighbourhood level of how the wider voluntary sector can support the innovation required, particularly with CVD which is the biggest cause of mortality in Cheshire.
- Halton are looking at the use of family hubs within neighbourhoods looking at children and young people and perinatal mental health.
- Sefton are undertaking work on a health and care strategic approach to expanding respiratory services for all ages, and a supported housing strategy for people with learning disabilities and autism. Patient flow out of inpatient stays for patients with learning disabilities and mental health becomes more complicated often involving accommodation options that are not easily found or sourced.

The Board Discussed –

- The Prime Minister and Lisa Nandy launched a covenant between central government and the voluntary sector, a case study at the launch event was around family hubs.



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- Finances and risk identification – low scores considering places are in deficit apart from Knowsley. Work is under way with the Assistant Directors of Finance to look at moderating the risks. Wirral place is in the correct position.
- Risk logs across the nine local authority areas – there is a degree of inconsistency looking across the priorities of the organisation. In the review of moderations, all nine places to be brought together for consistency.
- Health inequalities and the focus on using population health management tools which are available for all nine places. All places have got representatives on the population health academy.

The Board –

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

Committee AAA Report – Matters of Escalation and Assurance
ICB/11/24/11 – Highlight Report of the Chair of the ICB Remuneration Committee

The highlight report of the ICB Remuneration Committee was taken as read. No questions were received from the Board.

The Board noted the content of the report.
ICB/11/24/12 – Highlight Report of the Chair of the ICB System Primary Care Committee

The highlight report of the ICB System Primary Care Committee was taken as read. No questions were received from the Board.

The Board noted the content of the report.
ICB/11/24/13 – Highlight Report of the Chair of the ICB Women’s Hospital Services in Liverpool Committee

The highlight report of the ICB Women’s Hospital Services in Liverpool Committee was taken as read. No questions were received from the Board.

The Board noted the content of the report.
ICB/11/24/14 – Highlight Report of the ICB Strategic Commissioning and Transformation Committee

The highlight report of the Strategic Commissioning and Transformation Committee was taken as read. No questions were received from the Board.

The Board noted the content of the report.
ICB/11/24/15 – Highlight Report from the Chair of the Cheshire and Merseyside Health and Care Partnership (HCP)

The highlight report of the Cheshire and Merseyside Health and Care Partnership was taken as read. No questions were received from the Board.

The Board noted the content of the report.
ICB Business Items and Strategic Updates
ICB/11/24/16 – Shaping Care Together – establishment of a Joint Committee with NHS Lancashire and South Cumbria ICB

The Assistant Chief Executive provided an update to the board on the Shaping Care Together, establishment of a joint committee with NHS Lancashire and South Cumbria ICB. The joint committee will be responsible for the consideration of the pre-consultation business case for the Shaping Care Together programme, agreeing the commencement of public consultation and finally decision making on the final business case. The establishment of a joint committee was approved at the July 2024 Board meeting, the



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terms of reference support this. Lancashire and South Cumbria ICB signed off their terms of reference at their board meeting earlier in the month. The programme covers service transformation across Sefton, Formby and West Lancashire. The programme will follow NHS England major service change framework.

Financial matters related to the programme are to be reviewed. The Board are asked to approve the terms of reference, and a member from Cheshire and Merseyside ICB will either chair or be deputy chair with a Lancashire and South Cumbria Non-Executive Director. Decisions will be made locally as to who will be the executives on the panel.

The Board Discussed –

- The Terms of reference state as a joint committee of two ICB's there are joint financial implications. Work is underway that could lead to some service changes which related to services provided by Southport and Ormskirk Hospitals. The ICB cannot decide on a set of changes if some of the changes relate to Ormskirk; there needs to be a mechanism where changes can be made together and the three representative who attend the meeting know they have the full mandate of the Board. The Chief Executive is confident that this is the most effective way to conduct this business to mitigate risk.
- Discomfort in agreeing key conceding authority to a joint committee to commit the ICB to significant financial cost.
- Lancashire and South Cumbria ICB have approved their terms of reference.
- A specialist commissioning joint committee where the three ICB's in the North West make decisions on delegated responsibility together, and is currently chaired by Ruth Hussey.
- Mechanisms in place to engage Sefton Council, Lancashire County Council and West Lancashire District Council in the work of the joint committee. The Board was informed that Local authorities are already engaged locally with this work.

Actions-

- **Terms of reference to be revisited to ensure that the Cheshire and Merseyside Board has decision making authority, and only in a well thought out process do the committee members have the delegated authority to commit to decisions in the joint committee, to close the risk regarding finances. Action for the Assistant Chief Executive.**
- **Under section 5.9 of the Terms of Reference – change of wording to – a representative from both clinical and research. Action for the Assistant Chief Executive.**

The Board –

- **Considered the update on the programme and progress made to date.**
- **Approved the Joint Committee Terms of Reference with the caveat that the Assistant Chief Executive revisits the terms of reference to close the risk on finance.**
- **Approved the recommendation that the ICB Chair and Chief executive identify and agree the NHS Cheshire and Merseyside ICB representatives on the Joint Committee.**

ICB/11/24/17 – Proposal Regarding ICB Funded Gluten Free Prescribing Across Cheshire and Merseyside

The Medical Director spoke to the Board with a proposal regarding ICB Funded Gluten Free Prescribing across Cheshire and Merseyside, seeking the approval from the board to go out to public consultation. Gluten free products are prescribed for patients with celiac disease, which is an autoimmune condition. Eight out of the nine ICB places prescribe gluten free products, with 13,000 members of our population being diagnosed a celiac, 2300 people are currently receiving prescriptions for either bread, bread mixes and flours, 99% of those people are exempt from prescription charges, three quarters of those exemptions are due to age. 40% of ICB's across the nation have withdrawn funding for gluten free prescribing. Currently £500,000 is spent per year on those prescriptions. There are no prescriptions available for other intolerances such as lactose.

The Board Discussed –



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- Food poverty issue – in the process of consultation full engagement with foodbank networks be engaged within the region, as there may be added pressure on their services as a result of the consultation exercise.

The Board

- **Approved the commencement of a consultation exercise with the public and stakeholders regarding the proposed option to withdraw ICB funded gluten free prescribing across all of Cheshire and Merseyside.**

ICB/11/24/18 –NHS Cheshire and Merseyside ICB Constitution Updates

The Chief Executive provided an update to the board on the NHS Cheshire and Merseyside Constitution. When ICB's were established they were asked to adopt a model constitution prescribed by NHS England. There have been frequent occasions where NHS England have changed the guidance and have asked the ICB to update the constitution to reflect. All of the changes proposed are at the request of NHS England, and have to be adopted by the Board, who then go back to NHS England to ask them to approve changes to the constitution. A minor change would be nothing that would take authority away from the Board. All minor amendments will come back to Board for information.

The Board –

- **Considered the 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.**
- **Approved the proposed amendments to the Constitution.**
- **Approved progressing the process to submit an application to vary the Constitution to NHS England.**
- **Approved the recommendation to delegate authority to the Chief Executive to approve any minor changes to the Constitution following any feedback from NHS England.**

ICB/11/24/19 – NHS Cheshire and Merseyside ICB Board Assurance Framework and Corporate Risk Register 2024-25 Q2 Update

The Assistant Chief Executive provided an update to the board on the NHS Cheshire and Merseyside ICB Board Assurance Framework and Corporate Risk Register 2024-25 Q2 Update. There are ten principle risks, two critical, four extreme and four high. The two critical risks are not being able to meet the ICB financial duties and the lack of urgent and emergency care capacity. Risks are reported through respective committee structure.

The Board Discussed –

- P11 Digital Infrastructure Risks.
- Outlines mitigations and actions – there are significant gaps with mitigations and actions primarily due to funding, which needs to be better understood at Board level. The Chief Digital Information Officer advised that national funding has been identified, however the revenue component is being withheld and going to wider pressures; an update will be brought back to the March 2025 board meeting.

The Board

- **Approved the reduction in the current risk rating for P6, and the increase in the target score for P9 as described in section 2.3.**
- **Noted 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.**

ICB/11/24/20 – NHS Cheshire and Merseyside ICB Corporate Risk Register 2024-25 Q2 Update

The Assistant Chief Executive provided an update to the board on the NHS Cheshire and Merseyside ICB Corporate Risk Register 2024 – 25 Q2. There are ten risks on the risk register, one critical and nine extreme. The most significant risk being the East Cheshire Trust Summary Hospital Mortality Index risk (SHIMI).

The Board Discussed -

- Primary workforce –the last System Primary Care Committee not agree de-escalation, it asked for it to be reviewed across the four contractor groups. This will be discussed at the January 2025 Board meeting due to timing.

Action –

- **De-escalation of risk PC1 to be discussed at January 2025 board meeting.**

The Board –

- **Noted the Corporate Risk Register, progress in completing mitigating actions, further action planned, and assurances provided; and considered any further action required by the Board to improve the level of assurance provided.**
- **Did not approve the de-escalation of risk PC1 – for it to be discussed at January 2025 meeting.**
- **Approved the escalation of risks PC8 and T2.**

ICB/11/24/21 – NHS Cheshire and Merseyside ICB Primary Care Access Recovery Plan Update

The Assistant Chief Executive provided an update to the board on the NHS Cheshire and Merseyside ICB Primary Care Access Recovery Plan Update and introduced Chris Lees and Jonathan Griffiths to the meeting who spoke to the paper provided in the meeting pack, highlighting –

- The first plan was presented in November 2023 with an update in March 2024. This was in response to 9th May 2023 document Recovering Access to Primary Care. This is a GP access recovery plan. Thanks were given to all GP practices and the work that they do.
- Healthwatch are undertaking a piece of survey work on for Cheshire and Merseyside patients to understand the impact of this work across the ICB to see if this has made a difference to patient experience when accessing practices for appointments.
- A monthly report is sent to NHS England on the main ten areas. Place level improvement plans provide granular detail with individual practices.
- There are now more appointments in general practice, however there is increased demand. There is more workforce, but no more doctors.
- Digital telephony does not create any more appointments but makes the experience for patients better with a callback service.
- An increasing number of practices are moving to total digital triage which is helping to manage demand.
- There are patients that may not need to see a GP and can be diverted to pharmacy first.
- Primary secondary care interface is part of the primary care access recovery plan, work is being passed inappropriately between primary and secondary care. A consensus was published approximately two years ago which has been recognised nationally. There is a toolkit for Trusts to use to communicate the messages within the consensus. There are primary secondary care interface groups across acute Trusts. Trying to change culture and behaviours is difficult.
- There is currently collective action in general practice, demand is going up, and the lack of numbers of doctor increasing is being felt by GP's.

The Board Discussed –

- The Healthwatch survey is out and has been distributed in various ways, with a mixed response. Patient perception also plays a part in this. There is some improvement in pockets of areas. A commitment has been given to give a snapshot update to the System Primary Care Committee in December 2024 with a full Cheshire and Merseyside update in March 2025.
- Healthwatch in Wirral and Warrington have published information about pharmacy first.
- Workforce – the decline in GP practice nursing numbers, there are very few nurses nationally who chose general practice as a first destination and attracting non-medical staff into primary care. The universities training nurses should be contacted directly.
- Winter – some of the Places with the most pressure with patient flow are standing up acute hubs which will enable greater capacity in primary care.
- Estates – not having enough space to physically put more staff in general practice. PCN's have been asked to consider workspace creatively. The future route to investment and future capital monies in primary care is uncertain. Relationships with NHS Property Services can be managed and James Burchall is facilitating that process. There was significant investment in primary care estate twenty to

twenty-five years ago of LIFT schemes and third-party developments that will be coming to the end of their contractual lease terms. The Assistant Chief Executive and Director of Finance have been asked to think about how the primary care estates is strengthened and led in the future.

- There has been no increase in the number of GP's; the BMA are undertaking a piece of work on how many ARS clinicians a patient will see before a case is closed, compared to when they see a GP. GP's are then left with a very complex workload which is impacting on the exhaustion GP's are feeling.
- GP's have now been allowed to be employed as a part of the ARS scheme, however there are significant restrictions on who can be employed on a PCN level.
- Continuity of care for people with multiple illnesses.
- Encouraging the use of the NHS ap across all nine places.
- The reduction in the number of locum GP's.

The Board –

Discussed and noted the update on the System Level and Place Level Improvement plan(s).

ICB/11/24/22 – Intensive and Assertive Community Mental Health Care

The Wirral Place Director provided an update to the Board on Intensive and Assertive Community Mental Health Care. Guidance was received on 26th July 2024 about the opportunity to reflect on provision for people with severe and relapsing mental illness and the actions services needed to take to maintain the care of such people. Assurance was also sought that “Do Not Attend” was not being used as a reason for discharging vulnerable people. A comprehensive review was conducted by 30th September and assurance was received that the review was also about fact finding to inform national policy. Subsequent to 26th July guidance, a further letter was received from the National Lead Claire Murdoch and National Medical Director Dr Adrian Jones asking for the outcomes of reviews and action plans to be submitted to public Board meetings by 31st December 2025. The letter affirmed that further guidance would follow on what good looks like for community mental health services, what safe care looked like and what best practice looks like.

The submission was worked up along with NHS providers, mental health programme board and mental health trusts who are sighted at board level. The submission has also been cross-referenced with neighbouring ICB's, particularly regarding workforce and costings data. There are barriers and challenges around the availability and skills of the workforce as the skillset of the workforce has changed. The plan is split into what can be done with minimal resource, and longer term what may need additional resource. The cost estimates have been put forward, whilst consistent with neighbouring ICB's, it is identified that resources are unlikely to follow, and workforce is not there to meet the need. The collective submission across the three ICB's gives the national policy colleagues food for thought.

Next steps are to reconvene a task and finish group to continue to progress through mental health programme board, there is a community mental health services workstream.

Claire Haden advised the Board that nationally all ICB's feedback was collated and Cheshire and Merseyside ICB along with Greater Manchester and Lancashire and South Cumbria had very consistent themes nationally. There is recognition that this group of people have significant health inequalities, and it is essential to work as a system to address their needs. Nationally they are thinking about a support offer that includes training for specific staff, clearer guidance on the role of intensive assertive outreach. The 24-7 resource offer has significant implications.

The Board Discussed -

- Welcomed investment in mental health services to meet ever increasing demand, and the development of numbers of teams in communities. The approach around transformation of assertive outreach teams is the right one. To go to more teams in the first instance is the wrong approach and will create more hand-offs. The right step forward would be to start with the re-designing of the transformation of the emergency crisis approach.
- Governance - the task and finish group will be convened to confirm governance arrangements to bring back to Board. This may also be taken through a quality committee, sitting with the mental health programme board for delivery. There is infrastructure at programme level around community mental



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health transformation where it has been proposed and agreed that this will be the forum where much of the work will be undertaken and add detail to action planning.

The Board

- **Noted the requirements for this review report and action plan to be presented to ICB Public Boards by 31st December 2024.**
- **Noted the actions needed to be addressed to ensure that intensive community treatment and follow-up can be provided.**
- **Agreed that regular updates on progress against the action plan will be presented via established MH governance processes and reported through the Quality Committee for assurance.**

ICB/11/24/23 – Update on Progress Around Physical Health Checks for People with Severe Mental Illness in Cheshire and Merseyside

The Wirral Place Director provided an update to the board on Progress Around Physical Health Checks for People with Severe Mental illness in Cheshire and Merseyside, introducing Professor Chris Pritchard to the meeting, highlighting –

- The NHS offers a range of health checks for people with long term conditions and diseases to support prevention and early intervention. People with severe mental illness are offered checks and are more likely to present with physical health conditions which impact adversely on their quality and length of life. Most checks are delivered in primary care with a long-term target to offer checks on the basis of “don’t just screen, intervene” to 75% of these people with a 60% target for March 2025.
- People with mental health problems such as psychosis are at increased risk of dying at a younger age. Lots of the medications prescribed can increase the risk of chronic physical conditions such as coronary heart disease, type two diabetes and respiratory illness. Lifestyle choices such as smoking and obesity impact patients’ lives.
- This fits into the Core20PLUS5 agenda in terms of how the population is addressed to ensure there isn’t unwarranted variation in health inequalities.
- GP’s are expected to hold an up to date SMI register; across Cheshire and Merseyside there are approximately 31,000 people on the register. There is significant variation as thirty or forty years ago an individual may have had an SMI code added to their record, which still triggers a physical health check. There is an exclusion criterion that involves a manual trawl of individual notes for the last five years to see if they have had contact with mental health services.
- The six core physical health checks include alcohol consumption, blood pressure, blood glucose, height and weight check, checking cholesterol and smoking status. There are ten other checks as requested by NHS England which involve checking medical and family history, oral health, physical activity, immunisation or screening programmes, substance misuse, physical activity and medication reviews.
- Nationally published performance data looks for a target of 60% of people having all six health checks across 2024/25 with an expected increase of 75% the following year. Cheshire and Merseyside is at 55% after Q1. Q2 data was published on 21st November 2024, which has dropped to 52%, with the national England average at 57%.
- Examples of good practice on the Wirral - a voluntary sector organisation has been commissioned specifically to ensure health checks are undertaken and data is fed back into primary care. There are practices that can use a multimorbidity tool and the SMI health check covers 80% of the long-term condition health checks. Knowsley have implemented a one stop and shop and Merseycare have commissioned a service across Liverpool, Sefton and Knowsley for patients who do not access a GP practices.
- Some challenges are data flow and data quality issues meaning that data is not published nationally. There is some unwarranted variation across place, PCN and GP practice level across Cheshire and Merseyside and differences in how services are managed. There is a period of collective action with GP’s which may reduce appointments.
- Local and national data is being reviewed as a system to look for anomalies and data quality issues, working with the business intelligence and national team to ensure data is correct.
- There are well established intervention resources for individuals who have high blood pressure, diabetes, asthma, or any long-term condition.



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The Board Discussed –

- Voluntary and community sector and strategic commissioning plan thinking through how VCSE engagement activity can be embedded as a part of the delivery approach.
- Some of the language that is used is that some of the patients are difficult to engage, and changing services to make them more accessible for this cohort of patients.
- The importance of collaboration with delivery with the importance emphasised in neighbourhood working going forward.
- The need for partnership collaboration across the system, better planning and to look through the eyes of a patient.

Action -

- **Using tools such as CYFA to screen those with a code of severe mental illness cross referencing with the most common prescriptions. The Medical Director to connect with Professor Chris Pritchard to follow up.**

The Board –

- **Noted the content of this report and the accompanying presentation.**
- **Supported the sharing of the good practice identified within the presentation to improve uptake of the checks and interventions where needed.**

Meeting Governance

ICB/11/24/24 – Minutes of Previous Meeting

The Board reviewed the minutes of the meeting held on 26th September and 9th October 2024. The minutes of the NHS C&M ICB Board meeting of 26th September and 9th October 2024 were approved as accurate records of the meetings subject to the correction of one word “levers” on page 383 of the meeting pack.

ICB/11/24/25 – Board Action Log

The Board acknowledged the completed actions and updates provided in the document. The Board noted the Action Log and recommendations to close the completed actions. The Chair indicated that there are a number of outstanding actions for Executives to follow up on.

Any Other Business

ICB/11/24/26 – Closing Remarks and Review of the Meeting

The Chair summarised that it was a good meeting, with good discussion and challenges. The Chair thanked Board members for their continued contributions and support, and thanked members of the public for their attendance. The chair again thanked Chris Samosa and Claire Wilson for their contributions, passion and commitment and wished them well for their future.

Consent Items

ICB/11/24/27 – Board Decision Log

The Board reviewed the decision log and confirmed that the information presented was an accurate record of substantive decisions made by the Board up to 28th November 2024. 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

ICB/09/24/26 – Confirmed Minutes of ICB Committees

- Finance, Investment and Our Resources Committee – October 2024
- Health and Care Partnership – July 2024
- Quality and Performance Committee – September 2024
- Quality and Performance Committee – October 2024
- Women’s Hospital Services in Liverpool Committee – 2024
- Strategy & Transformation Committee – September 2024
- System Primary Care Committee – 2024

CLOSE OF MEETING

Date of Next Meeting:

Thursday 30th January - Ballroom, Bootle Town Hall, Oriel Road, Bootle, L20 7AE

Action Log 2023 - 2025

21.01.25

Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status	Recommendation to Board
25/01/2024	NHS C&M Quality and Performance Report	Board to receive information on secondary prevention measures in primary care (link to QOF)	Clare Watson	Mar-25	<i>Discussion ongoing with Performance team regarding access to reportable data that can be included within the integrated performance report. Data metrics will be agreed at System Primary Care Committee and then update to be provided to the Board</i>	ONGOING	
25/01/2024	Report of the Directors of Place	Board to receive a high level summary report at its November 2024 meeting on the Operating Model for Place, an understanding of the maturity of each , the learning across each Place and a focus on the priorities of each Place to drive out unwarranted variation	Graham Urwin, Clare Watson	Nov-24	<i>Deferred to February 2025</i>	ONGOING	
25/07/2024	NHS Cheshire and Merseyside Finance Report Month 2	Tony Foy to look at the level of assurance needed through the Quality Committee in terms of capability and capacity of the ICB to undertake impact assessments in a robust way.	Tony Foy	Nov-24	<i>This has been discussed at the Quality and Performance Committee and review of impact assessments is underway</i>	COMPLETED	<i>Board is requested to approve the closure of this action</i>
25/07/2024	Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative – Annual Work Plan	The Associate Medical Director to bring a polypharmacy agenda item to a future board meeting.	Fiona Lemmens	Mar-25	<i>Scheduled for March 2025 meeting</i>	COMPLETED	<i>Board is requested to approve the closure of this action</i>
26/09/2024	Report of the ICB Director of Nursing and Care	Alison Lee to bring a detailed recovery report on All Age Continuing Health Care to a future Board.	Alison Lee	Mar-25	<i>Scheduled for March 2025 meeting</i>	COMPLETED	<i>Board is requested to approve the closure of this action</i>
26/09/2024	Highlight Report of the Chair of the ICB Quality and Performance Committee	The Director of Nursing to pick up patient feedback and experience not being explicit in the Oversight exit criteria with Trish Bennett outside of the Board meeting.	Chris Douglas	Nov-24	<i>Meeting being arranged</i>	COMPLETED	<i>Board is requested to approve the closure of this action</i>
26/09/2024	Highlight Report of the Chair of the ICB Children and Young Peoples Committee	The Chair asked for the ICB to do some work on further understanding the pros and cons on whether we should use people who leave care, as a protected characteristic in the same way that statutory protected characteristics are used. Chris Samosa to bring an update to a future Board meeting	Mike Gibney	Mar-25	<i>Work has been undertaken and an update will come to Board in March 2025</i>	COMPLETED	<i>Board is requested to approve the closure of this action</i>
26/09/2024	Cheshire and Merseyside Urgent and Emergency Care Improvement Programme Update	Anthony Middleton to explore patient experience and quality as a part of sentinel metrics.	Anthony Middleton	Jan-25	<i>Q&P Committee have approved a number of changes to the Integrated Performance Report as part of a structured expansion to the overall report, future iteration will look to include other metrics subject to data quality, availability and clear objective</i>	COMPLETED	<i>Board is requested to approve the closure of this action</i>
26/09/2024	Cheshire and Merseyside Children and Young Peoples Elective Wait Recovery; Accelerated Delivery Proposal	Cheshire and Merseyside Children and Young Peoples Elective Wait Recovery; Accelerated Delivery Proposal to be discussed at November 2024 meeting with further updates from AMI	Anthony Middleton	Nov-24	<i>Paper being presented to January 2025 meeting</i>	COMPLETED	<i>Board is requested to approve the closure of this action</i>
28/11/2024	Report of the ICB Chief Executive	Anthony Middleton to circulate staff vaccination uptake figures with comparative data, with a breakdown of covid and flu vaccinations	Anthony Middleton	Jan-25	<i>Update to be provided in January performance report</i>	COMPLETED	<i>Board is requested to approve the closure of this action</i>
28/11/2024	Report of the ICB Director of Nursing and Care	The Director of Nursing to provide the Board with an update on the progress made to reduce risk factors of domestic abuse for staff (in twelve months time).	Chris Douglas	Nov-25	<i>Added to Board forward planner for November 2025</i>	COMPLETED	<i>Board is requested to approve the closure of this action</i>
28/11/2024	NHS Cheshire and Merseyside Integrated Performance Report	The Director of Performance and planning to look at the data that is broken down through an equality lens to understand the experiences of people with protected characteristics, for regular reporting back to board.	Anthony Middleton	Jan-25	<i>Data capability and quality is being assessed. Initial data will be considered at Quality and Performance Committee with a view to incorporating into integrated Performance report to Board or whether need to be a bespoke paper to Board on a cycle to be agreed. Update to be provided at March 2025 Board.</i>	ONGOING	
28/11/2024	Shaping Care Together - establishment of a Joint Committee with NHS Lancashire and South Cumbria ICB	Terms of reference to be revisited to ensure that the Cheshire and Merseyside Board has decision making authority, and only in a well thought out process do the committee members have the delegated authority to commit to decisions in the joint committee, to close the risk with joint finances.	Clare Watson	Jan-25	<i>Shaping Care Together update to be provided to Board meeting in Private which will provide an update on the issue raised and resolution</i>	COMPLETED	<i>Board is requested to approve the closure of this action</i>

Action Log 2023 - 2025

21.01.25

Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status	Recommendation to Board
28/11/2024	Shaping Care Together - establishment of a Joint Committee with NHS Lancashire and South Cumbria ICB	Under section 5.9 of the Terms of Reference – change of wording to – a representative from both clinical and research.	Clare Watson	Jan-25	<i>This change will be discussed with L&SC ICB to enable the change to be ratified.</i>	COMPLETED	<i>Board is requested to approve the closure of this action</i>
28/11/2024	NHS Cheshire and Merseyside ICB Corporate Risk Register 2024-25 Q2 Update	De-escalation of risk PC1 to be discussed at January 2025 board meeting	Clare Watson	Jan-25	<i>BAF is on January 2025 Board agenda and will be discussed.</i>	COMPLETED	<i>Board is requested to approve the closure of this action</i>
28/11/2024	Update on Progress Around Physical Health Checks for People with Severe Mental Illness in Cheshire and Merseyside	Using tools such as CYFA to screen those with a code of severe mental illness cross referencing with the most common prescriptions. The Medical Director to connect with Professor Chris Pritchard to follow up.	Rowan Pritchard-Jones	Jan-25	<i>Meeting has been arranged to discuss</i>	COMPLETED	<i>Board is requested to approve the closure of this action</i>

Meeting of the Board of NHS Cheshire and Merseyside

30 January 2025

Agenda Item No: ICB/01/25/30

Confirmed Minutes of ICB Committees

Click on the links below to access the minutes:

- Audit Committee – September 2024 ([CLICK HERE](#))
- Children and Young Peoples Committee – August 2024 ([CLICK HERE](#))
- Finance, Investment and Our Resources Committee – November 2024 ([CLICK HERE](#))
- Finance, Investment and Our Resources Committee – December 2024 ([CLICK HERE](#))
- Cheshire and Merseyside Health and Care Partnership – October 2024 ([CLICK HERE](#))
- Quality and Performance Committee – November 2024 ([CLICK HERE](#))
- Women's Hospital Services In Liverpool Committee – September 2024 ([CLICK HERE](#))
- Strategy & Transformation Committee – November 2024 ([CLICK HERE](#))
- System Primary Care Committee – October 2024 ([CLICK HERE](#))



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