NHS Cheshire and Merseyside

Annual Report and Accounts

2022-23

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1. Performance Report

Statement from the Accountable Officer

Welcome to the 2022-2023 Annual Report and Accounts of NHS Cheshire and Merseyside Integrated Care Board. This covers the nine-month period from the date of our establishment as a new statutory organisation on 1 July 2022. Integrated Care Boards were established with the purpose of:

1. Improving outcomes in population health and healthcare
2. Tackling inequalities in outcomes, experience and access
3. Enhancing productivity and value for money
4. Supporting broader social and economic development

I want to thank all ICB staff, NHS, local authority, and our wider partners for their sustained commitment and flexibility to deliver high quality patient care over the last nine months as we have implemented new health and care arrangements, continued to recover from the effects of the COVID-19 pandemic, and managed the impact of numerous industrial action events, all against the backdrop of global uncertainty and the cost-of-living challenge.

However, despite these numerous challenges, the past year has seen many successes, all of which are described in further detail throughout this annual report. I remain confident that health and care services across Cheshire and Merseyside continue to be designed and delivered in partnership with the purpose of ensuring the best possible care for our residents and examples of integrated care are described throughout this report.

Everything that has been achieved this year has come through long hours of hard work and, in many cases, teams going above and beyond what would normally be required. I am proud to work alongside such a committed group of people.

Despite only being in existence since 1 July 2022, the Integrated Care Board has benefitted from the combined knowledge and learning from our nine predecessor Clinical Commissioning Groups and the work undertaken by the former Health and Care Partnership, all which allowed the successful establishment of the Integrated Care Board.

As we look back on the previous year, our time is already now focussed on an ambitious agenda of improvement in 2023-24. We will seek to balance the short-term objectives of improving access – particularly through cutting waiting times for patients and primary care access is improved with these long-term objectives set out within our five-year forward plan, that will be published on 30 June 2023. I would welcome your comments on this year’s annual report and your views on how we can develop and mature as an organisation and achieve success in improving health outcomes for our population. Please send your comments to communications@cheshireandmerseyside.nhs.uk

1.1 Performance Overview

1.1.1 Purpose and activities of the organisation

NHS Cheshire and Merseyside – an Integrated Care Board – was established as a statutory NHS body on 1 July 2022.

Working within, and across, nine local authority areas – or 'Places' – its core purpose is to lead integration within the NHS, bringing together all those involved in planning and providing NHS services to take a collaborative approach to agreeing and delivering ambitions to improve the health of our population.

On establishment the statutory functions and duties, together with staff, assets and liabilities, of the nine legacy Clinical Commissioning Groups (CCGs) for Cheshire, Halton, Knowsley, Liverpool, South Sefton, Southport and Formby, St Helens, Warrington and Wirral were transferred to NHS Cheshire and Merseyside.

NHS Cheshire and Merseyside is responsible for the following specific functions:

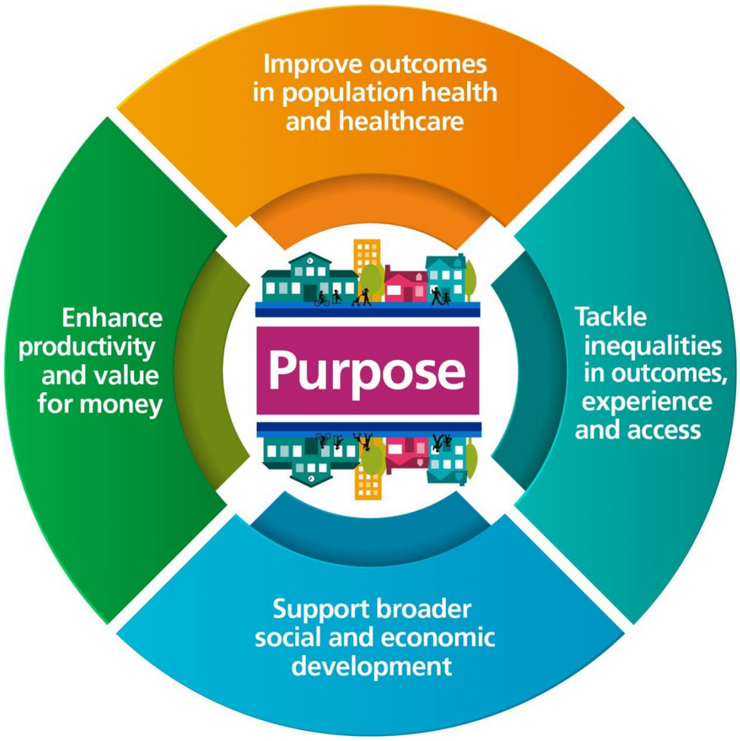
- **Developing a plan** to meet the health needs of the population of Cheshire and Merseyside, having regard to the Health and Care Partnership's strategy
- **Allocating resources** to deliver the plan across the system, including determining what resources should be available to meet the needs of the population in each place and setting principles for how they should be allocated across services and providers (both revenue and capital)
- **Establishing joint working arrangements** with partners that embed collaboration as the basis for delivery of joint priorities within the plan
- **Establishing governance arrangements** to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations, to ensure the plan is implemented effectively within a system financial envelope set by NHS England and NHS Improvement.
- **Arranging for the provision of health services** in line with the allocated resources across the Integrated Care System.
- **Leading system implementation of the People Plan** by aligning partners across the Integrated Care System to develop and support the 'one workforce', including through closer collaboration across the health and care sector, and with local government, the voluntary and community sector and volunteers.
- **Leading system-wide action on data and digital** by working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services and ultimately transform care to put the citizen at the centre of their care.

- Using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvement in performance and outcomes.
- Working alongside councils to **invest in local community organisations and infrastructure** and, through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the **NHS plays a full part in social and economic development and environmental sustainability**.
- **Driving joint work on estates, procurement, supply chain and commercial strategies** to maximise value for money across the system and support these wider goals of development and sustainability.
- **Planning for, responding to and leading recovery from incidents**, to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement.
- **Functions delegated by NHS England and NHS Improvement** including commissioning of primary care and appropriate specialised services.

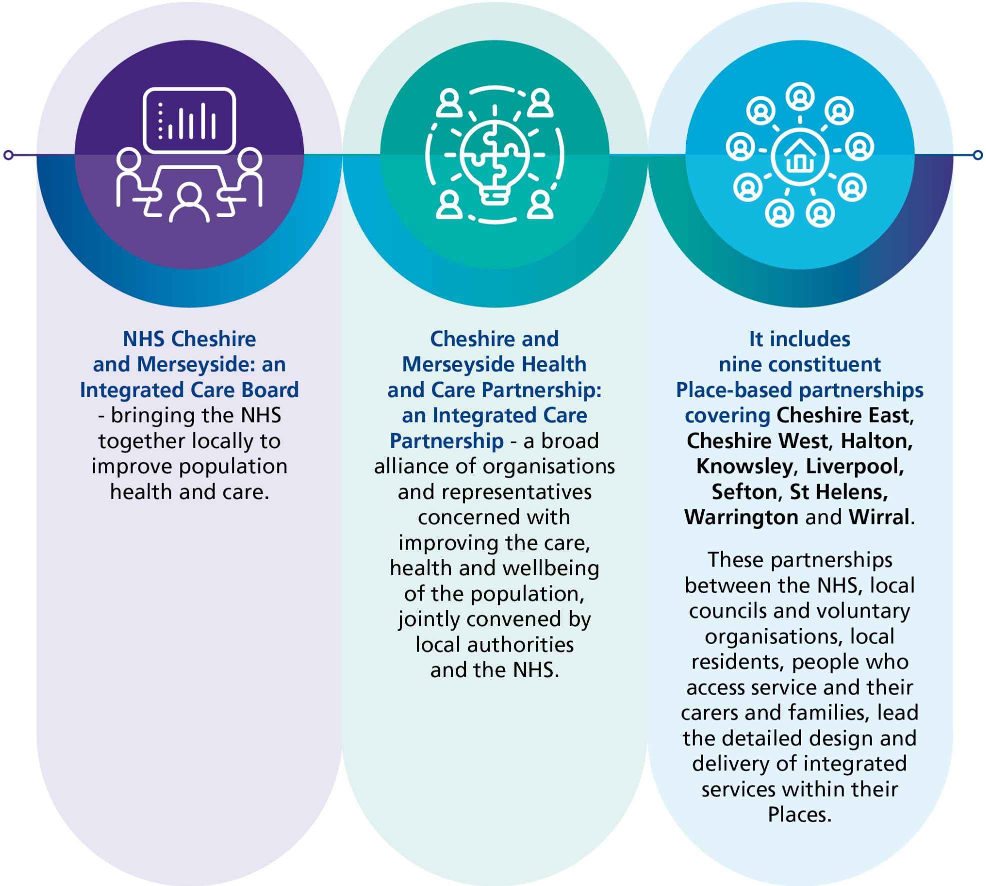
NHS Cheshire and Merseyside operates as part of a wider Integrated Care System (ICS).

The Health and Care Act 2022 established Integrated Care Systems on a statutory footing as partnerships that bring providers and commissioners of NHS services across a geographical area together with local authorities and other local partners to collectively plan health and care services to meet the needs of their local population.

<u>Core purpose of Integrated Care Systems</u>:



Cheshire and Merseyside's Integrated Care System comprises of:



There are also two wider provider collaboratives – groups of NHS providers working together with clinical networks and alliances and other partners to secure the benefits of working at scale. These are:

- Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST) with an immediate focus on the coordination of an effective provider response to current system and NHS priorities. In the medium and longer-term focus will shift to developing an overview of existing services, locations and pathways to ensure they are patient-centred, productive, streamlined and of high quality.
- Cheshire and Merseyside Mental Health, Learning Disability and Community Provider Collaborative, working at Place in partnership with local communities and all partners to commission and provide a population health focused approach to delivering connected mental health, learning disability and community services.

The national priorities for the NHS for 2022-23 were:

- **Health Inequalities** – maintaining focus on preventing ill-health and tackling health inequalities by redoubling efforts on the five priority areas for tackling health inequalities. Integrated Care Systems were required to take a lead role in tackling health inequalities, building on the Core20PLUS5 approach introduced in 2021-22 to support the reduction of health inequalities experienced by adults, children and young people, at both the national and system level.

- **Invest in our workforce** – with more people and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.
- **Respond to coronavirus (COVID-19) ever more effectively** – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.
- **Deliver significantly more elective care** to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.
- **Improve the** responsiveness **of urgent and emergency care (UEC) and build community care capacity** – keeping patients safe and offering the right care, at the right time, in the right setting. This needs to be supported by creating the equivalent of 5,000 additional beds, in particular through expansion of virtual ward models, and includes eliminating 12-hour waits in emergency departments (EDs) and minimising ambulance handover delays
- **Improve timely access to primary care** – expanding capacity and increasing the number of appointments available.
- Grow and improve mental health services and services for people with a learning disability and/or autistic people.
- Continue to develop our approach to population health management, prevent ill-health and address health inequalities.
- Exploit the potential of digital technologies to transform the delivery of care and patient outcomes.
- Make the most effective use of our resources.
- Establish Integrated Care Boards and collaborative system working.

NHS Cheshire and Merseyside has led the development and delivery of the system-level operational plan, working collaboratively with the Place-based partnerships and providers to ensure these priorities are met for our local population.

1.1.2 Performance appraisal / summary

Operational Performance: the key achievements and issues in relation to operational performance across the Cheshire and Merseyside Integrated Care System are summarised in this section. A more detailed commentary is provided in the performance analysis report at section 1.2 on page 14.

The urgent and emergency care system in Cheshire and Merseyside continued to experience significant pressures throughout the year. The health and social care system prepared extensively for winter, putting in place additional bed capacity, along with initiatives to both avoid admission and to facilitate discharge from hospital.

However, despite the best efforts of staff across the entire system, a combination of flu and COVID-19 pressures and problems discharging patients to the most appropriate settings resulted in an extended period of intense pressure. These factors resulted in a sustained period of very high bed occupancy, with significant numbers of patients who no longer meet the criteria to reside in hospital remaining in acute hospital beds, resulting in reduced ‘patient flow’ and associated delays for patients in A&E and out in the community in terms of ambulance calls.

The Cheshire and Merseyside Elective Recovery Programme, hosted by the Cheshire and Merseyside Acute and Specialist Trusts provider collaborative, made good progress in recovering elective activity (planned operations) during the year. This has resulted in waits of over 78 weeks being virtually eliminated by the end of the year and expected to be completed in the early part of next year.

The Cheshire and Merseyside-dedicated Diagnostics Programme which encompasses over 100 diagnostic tests has increased testing activity by 41% over pre-pandemic levels, significantly outperforming the England average. This has significantly improved waiting times for patients but there is still further to do to achieve the maximum six-week wait target.

There has been a sustained rise in suspected cancer referrals which has resulted in more cancer patients being diagnosed and treated than in any previous year. However, although a greater number of patients have been seen and treated within target times, high volumes have meant that significant numbers of patients have experienced delays.

Mental health services have experienced significant service pressures, both as a direct result of COVID-19 and as a symptom of the challenges of the wider system. Providers have experienced increased demand, acuity and complexity of cases. There were a number of areas of good and improving performance in relation to talking therapies, eating disorders, physical health checks, and access to peri-natal health checks. However delayed transfers of care are on an ongoing challenge, predominantly as a result of a lack of supported housing, nursing homes and suitable community placements. Workforce issues are also impacting on performance in some areas.

There has been continued improvement and development of primary and community care services. General practice appointment activity remains higher than that prior to the pandemic. The number of people awaiting community appointments has reduced. Alongside this there has been continued development of the urgent community response service and virtual wards to provide alternatives to hospital attendance or admission.

Strategic Plans: The ground-breaking All Together Fairer report for Cheshire and Merseyside, developed by Prof Sir Michael Marmot and his team, was published in May 2022 following the most comprehensive gathering of intelligence and research data on health inequalities in Cheshire and Merseyside ever completed.

In addition to intelligence about the current state of population health in Cheshire and Merseyside, All Together Fairer draws on a wider evidence base about what helps to reduce inequalities in health. This led to the development of an extensive set of evidence-based recommendations and an agenda for action on the social determinants of health that is central to the interim Cheshire and Merseyside Health and Care Partnership strategy.

Cheshire and Merseyside is building a national profile as an active 'Marmot Community' and an exemplar for system-level work on inequalities, including coordinated, consistent approaches to building healthy and inclusive economies and tackling the wider determinants of health. Achievements include:

- Building on the **key Marmot recommendations into our Health and Care Partnership strategy**
- **Launch** of the Cheshire and Merseyside Marmot Report with over 500 participants and media coverage
- Supporting the development and implementation of **Place based plans for All Together Fairer**
- Supporting the launch of the Liverpool City Region **Fair Employment Charter** and shared learning with Cheshire and Warrington to develop an equivalent charter
- Supporting a focus on **addressing systemic racism**
- Delivery of **wider determinants training**
- Contributing to the development of **Anchor Institutions** and the extension of the **Social Value Award** to NHS and system partners
- Progression of the **NHS Prevention Pledge**
- Development of **Marmot indicators** to monitor and inform Place-based implementation of the All Together Fairer programme.

Case Study: Supporting fair employment for all

Principle number three of the All Together Fairer programme, is to create fair employment and good work for all.

Being in employment is a key driver of good health. Employment that ensures a fair and secure contract and a degree of control for the employee enhances health.

With the support of the support of the All Together Fairer programme, two Fair Employment Charters are in development. In the Liverpool City Region area, the charter has been launched and businesses are signing up. In Cheshire and Warrington, the charter is at an earlier stage of development.

The All Together Fairer programme is supporting NHS employers to also sign up to the contract and to begin the work to meet the quality standards required to hold the charter.

The All Together Fairer programme is supporting the development through engaging public health directors and teams with Growth directors from each borough.

NHS Cheshire and Merseyside played a key role in the development of an interim Cheshire and Merseyside Health and Care Partnership Strategy, which was published in February 2023 ahead of a period of related public and stakeholder engagement with the intention to publish a final strategy during 2023-24.

Cheshire and Merseyside Health and Care Partnership is focused on tackling the big issues that need to be addressed to improve health and reduce the widening gaps in life expectancy between the poorest and wealthiest in our population.

NHS Cheshire and Merseyside's Digital and Data Strategy[1] - launched in early 2023 - describes our ambition to improve the health and wellbeing of our region right now and into the long term by weaving our digital and data infrastructure, systems and services throughout the pathways of care we provide. Turning intelligence into action through our population health management platform aims to improve the health of our entire population.

Significant transformation programmes including 'Beyond' for children and young people, our Cardiac Board, Diagnostics, Medicines Optimisation, Mental Health, Population Health Management and Prevention, Respiratory Network, and Women's Health and Maternity have continued to deliver benefits to our population in 2022-23. These are described in more detail in the performance analysis report at section 1.2 on page 14.

Financial Performance: NHS Cheshire and Merseyside delivered a surplus of £12.746m for the period 1 July 2022 to 31 March 2023 against its spending allocation.

NHS Cheshire and Merseyside has a number of financial duties under the NHS Act 2006 (as amended). For the period 1 July 2022 to 31 March 2023, NHS Cheshire and Merseyside achieved its financial duties as follows:

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

[1] https://www.cheshireandmerseyside.nhs.uk/about/digital-and-data-strategy/

Revenue resource use does not exceed the amount specified in Directions	Yes
Revenue administration resource use does not exceed the amount specified in Directions	Yes

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

- 14Z34 – Duty as to improvement in quality of services
- 14Z35 – Duty as to reducing inequalities
- 14Z36 – Duty to promote involvement of each patient
- 14Z37 – Duty as to patient choice
- 14Z38 – Duty to obtain appropriate advice
- 14Z39 – Duty to promote innovation
- 14Z40 – Duty in respect of research
- 14Z41 – Duty to promote education and training
- 14Z42 – Duty to promote integration
- 14Z43 – Duty to have regard to wider effect of decisions
- 14Z44 – Duties as to climate change
- 14Z45 – Public involvement and consultation by Integrated Care Boards
- 14Z49 – Duty to keep experience of members under review
- Contribution to the delivery of the Joint Health and Wellbeing Strategy

NHS Cheshire and Merseyside is confident that it meets its statutory duties, and this report provides details of the arrangements in place to facilitate delivery, which include roles and responsibilities, governance structures; strategies and plans; partnership and joint working arrangements; engagement and participation mechanisms.

1.1.3 Key issues and risks

The key issues, nationally and locally, impacting on NHS Cheshire and Merseyside in 2022-23, together with the opportunities and actions being taken to mitigate the impact on future delivery and performance are described below.

- While intensity of the COVID-19 pandemic has abated, the NHS throughout 2022-23 has continued to manage exceptional pressure and uncertainty. Major operational challenges arising from the pandemic included tackling backlogs, meeting deferred demand, new care needs, changing public expectations, enabling respite and recovery for those who had been at the frontline of the response, and re-adjusting to a post-pandemic financial regime. However, the lessons learned from the pandemic demonstrated the value of collaborative working, allowing faster decisions and better outcomes, creating resilience, and managing pressures through teamwork across organisations, sectors and professions. NHS Cheshire and Merseyside aims to create the conditions to continue to deliver these benefits, for example through Cheshire and Merseyside Acute and Specialist Trusts provider collaborative leadership of the elective recovery programme.

- There are long standing inequalities in health in Cheshire and Merseyside, as in the rest of England. Health outcomes in many areas are lower in this region compared to the national average and health inequalities within places are wider. Within each of the nine places, there are wide areas or smaller pockets of deprivation. Evidence shows that there are higher rates of obesity, smoking, poor mental health, cancer and preventable deaths across the area and these challenges are exacerbated by external factors such as poor housing conditions, unemployment, and poor education. The development of the Integrated Care System in Cheshire and Merseyside presents an opportunity to forge an action-based, accountable system that will generate greater health equity in the region based on partnerships with other sectors. The All Together Fairer 5-Year Strategy and Plan will deliver improvements at scale with local place plan implementation prioritised to meet local population needs.
- There are significant service and financial sustainability challenges across Cheshire and Merseyside. Liverpool University Hospitals NHS Foundation Trust is at system outcome framework level 4, indicating critical quality and / or finance issues and four other Trusts are at system outcome framework level 3 indicating significant support needs.
- The updated NHS Oversight Framework describes the approach to oversight and level and nature of support required across the new Integrated Care Systems using a four-tier methodology. Regional teams allocated Integrated Care Boards and Trusts to one of four ‘segments’ which indicate the range and nature of support required, from no specific needs (Segment 1) to a requirement for mandated intensive support (Segment 4).
- There was an anticipated £30m system financial deficit in 2022-23 and a substantial underlying ongoing system-wide financial deficit based on current service delivery models. Similarly the current economic climate presents financial challenges to local authority, business and voluntary and community partners.
- NHS Cheshire and Merseyside has been allocated to Segment 3 based on an assessment of the wider system challenge. Liverpool University Hospitals NHS Foundation Trust was placed in Segment 4 indicating critical quality and finance issues, four other trusts have been allocated to Segment 3 (significant support

need), 11 trusts to Segment 2, targeted support may be required, and two trusts to Segment 1.

- The Health and Care Act 2022 resulted in significant changes in the NHS operating environment, establishing Integrated Care Systems on a statutory footing, the abolition of CCGs, establishment of Integrated Care Boards and Provider Alliances with new functions and responsibilities, and delegation of further functions from NHSE. The Cheshire and Merseyside landscape is particularly complex with a population of 2.7m, 18 NHS Trusts, 9 local authorities, 355 GP practices and 590 pharmacies. The establishment of the Health and Care Partnership on a statutory footing and system working as a whole provides the optimum opportunity to address these challenges and to realise system wide efficiency opportunities through this collective system synergy and energy.

The principal risks identified by NHS Cheshire and Merseyside and the mitigating actions being taken are summarised below:

- NHS Cheshire and Merseyside is unable to meet its statutory duties to address health inequalities. This is being mitigated through the co-production of the Cheshire and Merseyside Health and Care Partnership strategy and Joint 5-year Forward Plan, led by the Health and Care Partnership Board.
- NHS Cheshire and Merseyside is unable to address inadequate digital and data infrastructure and interoperability which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities. This is mitigated through the Digital and Data Strategy 2022 to 2025 and supported programmes and projects.
- 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. This is being mitigated through the Elective Recovery Programme and Plans, Diagnostics Programme and Plans, Cheshire and Merseyside Cancer Alliance work programme.
- Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience. This is being mitigated through contractual standards and extensive infrastructure for quality review, analysis, learning and assurance.
- Lack of urgent and emergency care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience. This is being mitigated through the System Control Centre and system level operational planning and oversight.
- Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population. This is being mitigated through the development and delivery of the Primary Care Strategic Framework, Primary Care Access Recovery Plan, and Dental Improvement Plan.

- NHS Cheshire and Merseyside is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services. This is being mitigated through the transformation programmes in Liverpool, East Cheshire, and Sefton and for women's services and clinical pathways.
- NHS Cheshire and Merseyside is unable to achieve a system financial balance. This is being mitigated through system wide financial planning and the development and agreement of a system-wide financial plan for 2023-24 and 5-Year Financial Strategy.
- Unable to retain, develop and recruit staff to the Integrated Care System workforce reflective of our population and with the skills and experience required to deliver the strategic objectives. This is being mitigated through the development of workforce planning and implementation of organisational development strategy. This is being mitigated through a range of programmes developed and supported by the Cheshire and Merseyside People Board.
- Integrated Care System focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the Health and Care Partnership strategy and NHS Cheshire and Merseyside 5-year strategy on behalf of our population. This is being mitigated through the co-production of the Strategy and Joint Forward Plan, the development of Joint Committees with local authorities and memorandum of understanding with Place-based partnerships.

1.2 Performance Analysis

1.2.1 How performance is measured

Integrated Care Boards have the general statutory function of arranging health services for their population and are responsible for performance and oversight of NHS services within their Integrated Care System. During this 2022-23 year of establishment, NHS England has worked with Integrated Care Boards as they have taken on their new responsibilities, the ambition being to empower local health and care leaders to build strong and effective systems for their communities.

The NHS System Oversight Framework aims to support Integrated Care Boards and NHS England to work together and develop proportionate and locally tailored approaches to oversight that reflect:

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

- the importance of delivery against both the shared system priorities agreed between local partners and national NHS priorities.

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

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

The oversight framework is built around:

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

A three-step oversight cycle that frames how NHS England teams and Integrated Care Boards will work together to identify and deploy the right delivery support and intervention to drive improvement and address the most complex and challenging problems, respectively.

1.2.2 Performance monitoring systems and processes

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

- receive, review and scrutinise the integrated performance reports for NHS Cheshire and Merseyside with a focus on quality, safety and patient experience and outcomes.
- ensure that contract quality performance is monitored on a monthly basis (or other periods as agreed for certain contract types as appropriate)
- identify and scrutinise significant variations from plan of all Key Performance Indicators (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 NHS Cheshire and Merseyside
- ensure the implementation of the priorities set out in the Operational Planning Guidance
- oversee the ongoing delivery of procurements and any major service change, with a focus on quality, safety and patient experience in line with statutory requirements
- in relation to quality of services, seek assurance that the procurement of services is consistent with relevant laws and that conflicts of interest have been declared, managed and published as required

The NHS Cheshire and Merseyside Board receives a monthly performance report which provides on overview of key sentinel metrics drawn from the 2022-23 Operational plans, specifically Urgent Care, Planned Care, Cancer Care, Mental Health and Primary Care, as well as a summary of key issues, impact, and mitigations.

1.2.3 Performance metrics

1.2.3.1 Urgent and emergency care

	Latest performance					Year to Date performance			Comparison to England	
	Target	**By when**	**Latest position**	**Period**		**YTD performance**	**Period**		**England Average**	
Urgent and Emergency Care										
Mean average time of all C1 responses	00:08:00	Mar-23	00:08:27	Mar-23		00:08:42	Ave July 22 to Mar-23		00:08:49	
Mean average time of all C2 responses	00:18:00	Mar-23	00:30:56	Mar-23		00:42:27-	Ave July 22 to Mar-23		00:44:49	
Ambulance waiting more than 60 minutes from arrival to handover	0	Mar-23	8%	Mar-23		16.80%	Ave July 22 to Mar-23		10.30%	
Ambulance waiting less than 30 minutes from arrival to handover	95%	Mar-23	70.20%	Mar-23		65.60%	Ave July 22 to Mar-23		n/a	
Ambulance waiting less than 15 minutes from arrival to handover	65%	Mar-23	30.10%	Mar-23		27.40%	Ave July 22 to Mar-23		n/a	
Patients waiting for more than four hours from arrival to conclusion in A&E	95%	Mar-23	72.02%	Mar-23		70.81%	Ave July 22 to Mar-23		66.60%	
Patients admitted via A&E waiting more than 12 hours from decision to admit to admission to a ward	Less than 2%	Mar-23	19.30%	Mar-23		16.05%	Ave July 22 to Mar-23		11.17%	

Urgent and emergency services in England are recognised as facing a perfect storm of pressures impacting the whole health and care system and, at the end of the financial year, the urgent and emergency care system in Cheshire and Merseyside continues to experience significant pressures.

The health and social care system prepared extensively for winter, putting in place additional bed capacity, along with initiatives to both avoid admission and to facilitate discharge from hospital.

However, despite the best efforts of staff across the entire system, a combination of flu and COVID-19 pressures and problems discharging patients to the most appropriate settings resulted in an extended period of intense pressure. These factors have resulted in a sustained period of very high bed occupancy, with significant numbers of patients who no longer meet the criteria to reside in hospital remaining in acute hospital beds, resulting in reduced ‘patient flow’ and associated delays for patients in A&E and out in the community in terms of ambulance calls.

As a barometer of this pressure, all acute hospitals in England report daily against a nationally defined set of Operational Pressures Escalation Levels (OPEL). The majority of Trusts across Cheshire and Merseyside have been consistently reporting at OPEL 3 for an extended period since 1 July 2022. OPEL 3 is defined as ‘the local health and social care system is experiencing major pressures compromising patient flow’.

In October 2022, NHS England published guidance on System Control Centres, and required all Integrated Care Boards to establish a System Control Centre by 1 December 2022. System Control Centres operate at an Integrated Care Board-level to lead and facilitate collaboration through senior system-level operational leadership on a day-to-day basis. The aim was to deliver visibility of operational pressures and risks across providers and system partners and to enable concerted action on key systemic and emergent issues impacting patient flow, ambulance handover delays and other performance, clinical and operational challenges. System Control Centres operate seven days a week, 365 days a year, with 8am to 8pm staffed provision. NHS Cheshire and Merseyside set its SCC up on schedule and to the required specification and has been instrumental in the system response to urgent and emergency care challenges over the course of the remaining months of 2022-23.

As winter pressures increased over the course of December and into January a total of six Trusts across Cheshire and Merseyside declared the highest level of escalation, OPEL 4 on one or more occasions, with 15 separate declarations over this period, and a further period of pressure in March resulting in several further OPEL 4 declarations.

Category 1 Ambulance standard: These most immediately life-threatening calls should be responded to within eight minutes. The average performance from 1 July 2022 to March 2023 was 8 minutes 42 seconds.

Category 2 ambulance standard: These calls should be responded to within 18 minutes and includes serious presenting conditions including patients who may have had a stroke or are experiencing chest pain. The average performance from 1 July 2022 to March 2023 was 42 minutes 27 seconds. Performance deteriorated significantly in late 2022 in the context of the winter pressures described above, reaching an average for December 2022 of 1 hour 53 minutes and 3 seconds. While there was improvement in response times in February 2023 to 22 minutes 35 seconds, pressure in March resulted in an increase to 30 minutes and 56 seconds.

Ambulances waiting more than 60 minutes from arrival to handover: Due to reduced ‘patient flow’, patients arriving at our hospitals have experienced significant delays in the handover between the ambulance service and hospital staff in A&E. Part year to date, from July 2022 to March 2023, 16.8% of ambulances have been delayed for over 60 minutes, and this in turn contributes significantly to the delayed ambulance response times outlined above, due to fewer ambulances being available to respond to calls.

Patient waits from arrival in A&E: The national waiting time target remains the so called four-hours standard, based on the NHS Constitution which states that at least 95% of patients attending A&E should be admitted to hospital, transferred to another provider, or discharged within four hours. Performance from 1 July 2022 to March 2023 averaged 70.81% with a year-end performance in March of 72.02%, this is better than the England average for 2022-23 of 66.60% but still reflects a situation where many patients are experiencing extended waiting times. A national recovery ambition of 76% has been set for 2023-24, and NHS Cheshire and Merseyside is planning on achievement of this improvement milestone.

Patients admitted via A&E waiting more than 12 hours from decision to admit: Overcrowding caused by insufficient bed capacity available within our hospitals to admit all those patients requiring a hospital bed. This leads to patients having to wait for a bed in the ED or on an assessment unit, as can be seen from the increasing number of patients experiencing a delay of over 12 hours from the point of a decision to admit.

Case Study: Two-hour Urgent Community Response service for Cheshire East and West

The two-hour community response service enables care to be delivered rapidly for a range of acute conditions and exacerbations of frailty without the need for an acute hospital admission.

One example of an invaluable two-hour response is that of an elderly patient whose mobility had reduced markedly over the previous 24 hours. The patient had a diagnosis of dementia and lived with their spouse, who also had significant health problems. Following a home visit which identified no acute cause of the reduced mobility, the two-hour community response was mobilised via a call to a single point of access. The patient was assessed within an hour by a nurse practitioner who performed baseline investigations. The patient's care was stepped up appropriately when infection was later identified. As a result, support was mobilised for both the patient and their spouse.

The benefit here is that the patient avoided an acute admission via A&E and a long stay on an acute medical ward, which would have increased the risk of delirium and deconditioning.

From a system perspective, it reduced pressure on A&E and ambulance services and, from a GP perspective, it was re-assuring that, only four hours after the initial call to the GP practice, the patient had been assessed and a management plan put in place.

1.2.3.2 Planned care

	Latest performance					Year to Date performance			Comparison to England	
	Target	By when	Latest position	Period		YTD performance	Period		England Average	
Planned care										
The number of incomplete Referral to Treatment (RTT) pathways (patients waiting to start treatment) of 104 weeks or	0	Jul-22	16	Mar-23		16	Mar-23		12	

more at the end of the reporting period										
The number of incomplete RTT pathways (patients yet to start treatment) of 78 weeks or more	0	Apr-23	349	Mar-23		349	Mar-23		156	
The number of incomplete RTT pathways (patients yet to start treatment) of 52 weeks or more	Reduction from March 22 (16,604)	Mar-23	18,255	Mar-23		18,255	Mar-23		6,880	
The percentage of patients who have not yet received treatment, and whose pathway is considered to be incomplete (or ongoing), that were waiting less than 18 weeks at month-end	92%	Mar-23	56.29%	Mar-23		56.22%	July 22 to Mar-23 ave		60.40%	
Elective recovery - increase elective activity by 10% - overall	110%	Mar-23	100.90%	Mar-23		97.70%	July 22 to Mar-23 ave		96.50%	
Elective Recovery - Increase elective activity by 10% - Admitted care	110%	Mar-23	116.00%	Mar-23		88.95%	2022-23		85.60%	
Elective Recovery - Increase elective activity by 10% - Daycase	110%	Mar-23	138.00%	Mar-23		95.11%	2022-23		98.40%	
Elective Recovery - Increase elective activity by 10% - First outpatient	110%	Mar-23	121.00%	Mar-23		98.26%	2022-23		100.20%	
Reducing outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023	-25% reduction	Mar-23	+16.7%	Mar-23		-1.50%	2022-23		-0.90%	

Expanding the uptake of Patient Initiated Follow Up (PIFU) to all major outpatient specialties, moving or discharging 5% of outpatient attendances to PIFU pathways by March 2023.	5%	Mar-23	2.20%	Mar-23		1.80%	July 22 to Mar-23 ave		1.70%	

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

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

104 week waits: Due to the backlog of elective patients that built up during the pandemic, the numbers of patients waiting over 104 weeks for treatment grew from 30 in April 2021 to a peak of 1,235 in February 2022. Due to the focused work on long waits, by the end of July 2022, long waits were substantially reduced, and no patients were waiting over 104 weeks except for the legitimate exemptions around patient choice. As at the end of March 2023 16 patients were awaiting treatment at 104 weeks or over, with the majority due to patient choice and a small number due to complexity, however the majority of these patients had ‘To Come In’ (TCI) dates in April 2023.

78 week waits: The national ambition is to eliminate waits in excess of 78 weeks by the end of March. Cheshire and Merseyside trusts have been making significant progress in reducing the numbers of patients waiting 78 weeks or longer. In the 29 weeks to end March 2023 Cheshire and Merseyside NHS trusts cleared 39,576 patients in this cohort, and at year end 349 patients registered to General Practices in Cheshire and Merseyside were reported as having waited over 78 weeks. 12 patients were subsequently confirmed to have been reported in error and had not breached. Of the 337 remaining breaches 111 were due to patient choice, 107 were due to complexity, or the patient being unfit for treatment, and the remaining 119 are classified as capacity breaches against the 78-week ambition. The majority of these patients had ‘To Come In’ (TCI) dates in April 2023.

52 week waits: Prior to the pandemic, waits of over 52 weeks for elective treatment had been eliminated in Cheshire and Merseyside. The ultimate goal is to return to this position. National ambitions have therefore been set in pursuit of this goal, with key milestones being the elimination of 104 and 78 week waits as described above, the elimination of over 78 week waits by the end of March 2023, and the elimination of over 65 week waits by March 2024. This goal is reflected in our operational plans for 2023-24.

Increase elective activity by 10%: The NHS *Delivery plan for tackling the COVID-19 backlog of elective care* (February 2022) set an ambition to deliver over 10% more elective activity than before the pandemic. Some of this increase is expected to be delivered by reducing outpatient follow-up appointments, encouraging patient initiated follow up, and improving pre-referral advice and guidance. The year-to-date performance shows that while these ambitions have not been achieved, Cheshire and Merseyside elective recovery is broadly in keeping with the England average and outperforms the England average in terms of delivery of admitted elective care.

The Cheshire and Merseyside Acute and Specialist Trusts provider collaborative hosts the Cheshire and Merseyside Elective Recovery Programme. The programme is a key enabler for the elective activity and the reduction of the longest waits for treatment. The programme has been instrumental in the significant progress made towards eliminating 104 and 78 week waits and has facilitated the provision of mutual aid between hospitals in Cheshire and Merseyside for more than 3,500 patients in order to expedite their treatment. The programme has also played a key role in driving improvements in theatre productivity and ain bidding for and mobilising additional elective capacity.

1.2.3.3 Diagnostics

	Latest performance					Year to Date performance			Comparison to England	
	Target	By when	Latest position	Period		YTD performance	Period		England Average	
Diagnostics										
Increase the number of diagnostic tests to at least 120% of pre-covid baseline	120%	Mar-23	114.50%	Mar-23	●	104%	YTD to Mar-23	●		●
The proportion of patients waiting more than 6 weeks for a diagnostic test at the end of each month.	Less than 1%	Mar-23	18.85%	Mar-23	●	22%	July 22 to Mar-23 ave	●	28.95%	●

For diagnostics the national waiting target remains at <1% waiting over six weeks for a diagnostic test and zero 13+ week waiters with a recovery ambition of 95% of patients receiving a test within six weeks by March 2025. Currently in England fewer than 70% of patients receive their test within six weeks. A national activity target has also been set at 120% of pre-pandemic levels, specifically 2019-20 activity baseline across a range of seven common diagnostic modalities. Cheshire and Merseyside is at 141% as at December 2022, compared to 104% for England.

Cheshire and Merseyside is one of the few Integrated Care Boards to have a dedicated Diagnostics Programme which encompasses all (over 100 tests) diagnostics. Other Integrated Care Boards are looking to replicate these arrangements so that all tests are provided in ways which maximise productivity and effectiveness. 2022-23 was the first full year for this Transformation Programme which has been a key enabler for the following:

Increased Activity

- Six Community Diagnostic Centres (CDCs) have opened in Cheshire and Merseyside and we are delivering the 3rd highest level of CDC activity in England.
- A further three Community Diagnostic Centres are due to open in the first half of 2023 with activity levels set to increase from c150,000 tests in 2022-23 to c340,000 tests in 2023-24.
- Across all sites (including the six Community Diagnostic Centres) 105,000 tests are being delivered each month, an 18% growth over 12 months.
- 700+ sleep studies completed per month compared to 96 in April 2020.

Investment Secured

- Secured £112m capital investment to deliver additional activity and modernise diagnostic kit and facilities.
- Secured capital to ensure all trusts have two CT scanners so if unplanned downtime experienced on a machine, patients can still be scanned.
- Secured investment for estates renovation in (East Cheshire and Southport) enabling all Cheshire and Merseyside trusts to now provide a bowel screening service.

Reduced Waiting Times

- 76% of patients are seen within six weeks compared to 75% 12 months ago.
- 94% of patients received an MRI in six weeks compared with 30% in April 2020.
- 93% of patients received a CT scan in six weeks compared with 41% in April 2020.
- Waiting list for Echocardiography reduced from 10,372 patients to 7835 patients between January 2022 and March 2023. Percentage seen within six weeks moved from 42% in April 2020 to 81% in March 2023.
- Waiting list for Gastroscopy reduced from 7,222 patients to 4,220 patients between December 2021 and December 2022. Percentage seen within six weeks moved from 39% to 61%.

Cheshire and Merseyside ranked 11th out of 42 Integrated Care Systems for diagnostic performance in 2022-23, an improved position compared to a ranking of 20th 12 months ago.

1.2.3.4 Innovation and digitalisation

- Introduction of region wide naso-endoscopy service delivering an innovative new service for 4,000 patients. Reduced discomfort and recovery time.
- Connected PACS (Picture Archiving Comms) system in place across all trusts so images can be shared to reduce the need to rescan patients and support faster diagnosis.
- Real time productivity tool rolled out to all endoscopy departments which is supporting the drive to reduce Did Not Attend rates to less than 5% so that appointments are not wasted.

1.2.3.5 Cancer

	Latest performance					Year to Date performance			Comparison to England	
	Target	By when	Latest position	Period		YTD performance	Period		England Average	
Cancer										
The percentage of patients referred for cancer treatment by their GP who waited for less than 14 days for treatment to start	93%	Mar-23	77.70%	Mar-23		76.20%	Rolling 12 months to Mar-23		83.90%	
The percentage of patients referred on a breast symptomatic pathway by their GP who waited for less than 14 days for treatment to start	93%	Mar-23	64.30%	Mar-23		59.40%	Rolling 12 months to Mar-23		77.60%	
Cancer patients receiving first definitive treatment within 2 months of referral for suspected cancer	85%	Mar-23	67.40%	Mar-23		66.60%	Rolling 12 months to Mar-23		63.50%	
Number of patients receiving communication of diagnosis for cancer or ruling out of cancer, or a decision to treat if made before a communication of diagnosis, within 28-days following an	75%	Mar-23	70.40%	Mar-23		66.80%	Rolling 12 months to Mar-23		74.20%	

urgent referral for suspected cancer.										
Meet the increased level of referrals and treatment required to address the shortfall in number of first treatments	>100%	Mar-23	111.80%	Mar-23		114.00%	July 22 to Mar-23		106.30%	
The percentage of patients diagnosed with cancer receiving treatment within 31 days of diagnosis	96%	Mar-23	94.80%	Mar-23		94.40%	Rolling 12 months to Mar-23		91.90%	

The Cheshire and Merseyside Cancer Alliance (CMCA) leads on developing and improving NHS cancer services on behalf of the ICB. The Cancer Alliance oversees a comprehensive portfolio of programmes leading on prevention, earlier diagnosis, improving operational performance, developing the workforce and addressing health inequalities. Our focus is on creating better cancer services, better cancer care and better cancer outcomes for the population of Cheshire and Merseyside, including reducing variation and ensuring the best patient experience across the region.

The Cancer Alliance works closely with all Cheshire and Merseyside NHS services supporting improved efficiency and productivity with funding and project resources through the faster diagnosis programme. Further information about the work of the Cheshire and Merseyside Cancer Alliance, is in our latest annual report[2], and on our website[3].

Patients referred on a suspected cancer pathway seen within two weeks: There has been a sustained rise in urgent suspected cancer referrals, and these continue to trend upwards. Between April 2022 and March 2023 the overall number of patients referred on a two-week referral pathway was 158,598 compared to 144,918 in the previous 12-month period.

High referral levels have resulted in more cancer patients being diagnosed and treated than in any previous year. However, although a greater number of patients have been seen and treated within target times, high volumes have meant that significant numbers of patients have experienced delays. Thus, performance against the 14-day standard still remains below target at 77.7%, and short of the England performance of 83.90%. The 12-month rolling average from April 2022 to March 2023 was 76.2% in Cheshire and Merseyside compared with 79.5% for England overall.

Non-suspected breast symptomatic: High levels of referrals have impacted on performance of the non-suspected-cancer breast symptomatic standard.

[2] https://cmcanceralliance.nhs.uk/about/documents-policies
[3] https://www.cmcanceralliance.nhs.uk/

Performance in March 2023 was 64.30% against an operational standard of 93%. The 12-month rolling average was 59.40% in March 2023.

Cancer patients receiving first definitive treatment within two months of referral for suspected cancer (62-day standard): The national standard of 85% is not being met. A significant deterioration in performance occurred nationally in January, as a result of the UEC pressures described above, however performance improved and in March 2023 67.40% was achieved (compared to 63.50% for England), with a rolling 12-month performance of 66.6%. The number of patients waiting more than 62 days for a diagnosis or treatment (aka the over 62-day backlog) remains a concern. Nearly half the backlog is made up of patients on suspected lower gastro intestinal cancer pathways. The over 62-day cancer backlog stood at 1,364 as of 31 March 2023 compared to nearly 2,500 in January 2023.

Number of patients receiving communication of diagnosis for cancer or ruling out of cancer, or a decision to treat if made before a communication of diagnosis, within 28 days following an urgent referral for suspected cancer: The 28-day faster diagnosis standard is a significant challenge, with performance in Cheshire and Merseyside below the regional and national averages, however performance against the national standard of 75% continued to improve in 2022-23 and as of March 2023 70.40% was achieved, versus the 12-month rolling average of 66.8%. Further improvement and achievement against the 28-day standard is a key priority for 2023-24. All providers have confirmed planning trajectories (including mid-year milestones) to be fully compliant by March 2024 in line with the national expectation.

Total patients treated for cancer compared to same period pre-COVID-19: As outlined above, high referral levels have resulted in more cancer diagnoses and treatments than ever before. In March 2023, treatment levels in Cheshire and Merseyside were 111.8% compared to 106.3% nationally.

Patients treated within 31-days of diagnosis: Performance against the national standard of 96% continued to improve in 2022-23 and as of March 2023 94.40% was achieved.

1.2.3.6 Mental health

	Latest performance					Year to Date performance			Comparison to England	
	Target	By when	Latest position	Period		YTD performance	Period		England Average	
Mental Health										
Psychological Therapies recovery rate	50%	Mar-23	50.00%	Q4 22-23	●	48.20%	Ave Jul-22 to Mar-23	●	50.40%	●

The number of IAPT Referrals Entered Treatment	Ave 20,115.5 per quarter; 6,705 ave per month	Mar-23	5,120	Mar-23	●	39,220	Jul-22 to Mar-23 cumulative	●	n/a	●
Inappropriate use of out of area Mental Health bed days	Ave 319.5 per quarter; 106.5 per month	Mar-23	975	Mar-23	●	545	Month ave to Mar-23	●	n/a	●
Dementia Diagnosis Rate	67%	Mar-23	65.1%	Mar-23	●	64.3%	Ave Jul-22 to Mar-23	●	62.50%	●
Women accessing perinatal Mental Health services	2,729	Mar-23	2,475	Full year 2022-23	●	2,475	Full year 2022-23	●	n/a	●
Proportion of children with Eating Disorder (routine cases) that start treatment within 4 weeks	94.85%	Mar-23	83.2%	Full year 2022-23	●	83.2%	Full year 2022-23	●	78.00%	●
Proportion of children with Eating Disorder (Urgent cases) that start treatment within 1 week	94.74%	Mar-23	80.6%	Full year 2022-23	●	80.6%	Full year 2022-23	●	71.70%	●
People with severe mental illness having a full physical health check in the previous 12 months	17,673 (60%)	Q4 22-23	51.6%	Full year 2022-23	●	51.6%	Full year 2022-23	●	58.50%	●
Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services	16,077 Q1; 5,418.5 per month	Q4 22-23	13,705	2022-23	●	13,705	2022-23	●	n/a	●
People with a first episode of psychosis beginning treatment within 2 weeks	59.93%	Mar-23	58.3%	Mar-23	●	61.6%	Ave Jul-22 to Mar-23	●	72.20%	●

Children & young people accessing mental health services with at least one contact	Ave 33,880	Mar-23	28,740	2022-23		28,740	2022-23		n/a	

In the same way as described above for urgent and emergency care and elective care, mental health providers across Cheshire and Merseyside have experienced significant service pressures, both as a direct result of COVID-19 and as a corollary of the challenges of the wider system.

Increased demand, acuity and complexity of cases have resulted in system wide pressure and adverse impacts on mental health acute care flow. NHS Cheshire and Merseyside is not currently meeting the national ambition to eliminate out of area placements for adults in acute inpatient care as a result.

Mental Health Delayed Transfers of Care are on an ongoing challenge, predominantly as a result of a lack of supported housing, nursing homes and suitable community placements.

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

Talking Therapies: IAPT (Improving Access to Psychological Therapies) recovery rate improved to 50.20% in February 2023, achieving the 50% target, however the average between July 2022 and January 2023 remained just below the target at 47.6%. Clinical leads and supervisors continue to review individual recovery rates to look at ways to help each therapist improve their own recovery rates. Access rates for Talking Therapies also remain significantly below target and plans to address this have been developed as part of 2023-24 operational planning processes.

Dementia Diagnosis: Four out of nine sub-Integrated Care Board areas have achieved the dementia diagnosis target rate of 66.7%, however, the overall access rate at Integrated Care Board-level has remained relatively static post COVID-19 at 64.30%, having previously met the target on a consistent basis. This is slightly better than the England average at 62.50%. A diagnostic tool designed specifically for use in care home settings, DiADeM (Diagnosing Advanced Dementia Mandate), is being piloted in two specific areas where rates have been static and good practice is being shared via the Dementia Clinical Network to improve access rates.

Perinatal Mental Health Access: Although currently anticipated to be one year behind trajectory as a result of workforce challenges, progress is positive in respect of perinatal mental health access and was on track to achieve the recovery plan target of 2,357 by the end of March 2023. However, ongoing data quality issues are resulting in this currently not being reflected in nationally published data and work is underway to address this.

Eating Disorders: Eating Disorder services for children and young people continue to receive referrals significantly above pre-COVID-19 levels. Assessments are routinely available within four weeks of referral, with a small number of breaches due to appointment attendance, in 2022-23 Cheshire and Merseyside achieved 83.20%

for routine referrals. While this is below the target of 94.85%, but better than the England average of 78.00%, this is not currently reflected in the nationally published data and actions are being addressed to improve data quality. For urgent 1-week referrals, Cheshire and Merseyside achieved 80.6% against a target of 94.7%, which was better than the England average of 71.70%.

Access to Physical Health Checks for people with Severe Mental Illness (SMI) are continuing to improve following the deployment of additional non-recurrent funding to support tailored outreach services. Place level access rate increases of between 4% and 11.7% were reported between quarter 3 and quarter 4.

A System Recovery Action Plan (RAP) for Individual Placement Support (IPS) services was agreed by NHS England with an expectation that delivery would be one year behind the LTP ambition by March 2023. Access has not increased as quickly as anticipated as a result of recruitment and retention difficulties. However, one of Cheshire and Merseyside's IPS Providers, Standguide, has been advised that they are the highest scoring IPS service in the whole country following their recent fidelity review.

Published data for community mental health services indicate that access rates are declining. However, this is not the case and is as a result of data not flowing for the increased levels of activity being undertaken by primary care mental health practitioners employed via the Additional Roles Reimbursement Scheme (ARRS). Plans are being developed to ensure activity is being appropriately captured via national reporting routes. 81% of Primary Care Networks (PCN) now have at least one mental health ARRS roles in post with plans to achieve 100% by quarter 1 of 2023-24.

Performance against the 60% target for early intervention in psychosis treatment within two weeks was 58.3% in March 2023, however the average between July 2022 and March 2023 achieved 61.60%. Breaches are attributed to a high number of vacancies, large caseloads and increased number of referrals. The position is expected to improve as vacant posts have been filled and caseloads have reduced, providing more capacity to meet the two-week target.

Mental Health in School Teams have been implemented in all nine Places and continue to contribute to Children and Young People's mental health access rates. However, further work is required to ensure that all of this activity is captured in data sets and appropriately reported.

Workforce is a continued significant risk in terms of delivery of the mental health Long Term Plan ambitions, across a wide range of staffing groups.

1.2.3.7 Learning disability and autism

	Latest performance					Year to Date performance			Comparison to England	
	Target	By when	Latest position	Period		YTD performance	Period		England Average	
Learning disability & autism										
Learning disability registers and annual health checks delivered by GPs	75%	Mar-23	80.4%	Mar-23	●	80.4%	Mar-23	●	80.60%	●
Inpatient care for people with learning disability and/or autism (per million registered population)	15	Mar-24	49.0	Mar-23	●	50.0	Ave Nov-22 to Mar-23	●	43	●

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

Learning Disabilities Health Checks: The NHS Long Term Plan set an ambition is that by 2023-24, at least 75% of people aged 14+ with a learning disability will have an Annual Health Check (AHC). Cheshire and Merseyside surpassed the target of 75%, accomplishing 80.40% of people having had an AHC by March 2023.

Inpatient care for people with learning disability and/or autism (adult): Performance challenges in this area include ongoing pressure on ATU bed capacity, in part due to delayed discharges. Delays in identifying suitable housing and fitting the essential adaptations contribute to delayed discharges, as do workforce issues in terms of recruiting teams to support patients in the community. These delays in turn can affect the health and wellbeing of the patient and have a wider impact on families. Transforming Care staff are helping with the backlog of Care and Treatment reviews (CTR's) within Specialised Commissioning where a number of people have also been identified as delayed discharges. An Intensive Support Function has been commissioned across Cheshire and Merseyside which supports people in the community who may be in crisis and aims to avoid hospitalisation.

Inpatient care for people with learning disability and/or autism (children): In March 2023 there were five children and young people (CYP) with LD/A in a tier 4 bed. The target is to minimise episodes of inpatient care. Fewer admissions and shorter length of stay will generally have a positive impact on a child or young person's care and treatment. A Dynamic Support Register has been developed to enable the identification of children and young people at risk of admission much sooner to ensure admissions are appropriate and hospital admission avoidance is achieved where it is deemed appropriate. Similarly, the escalation process is being used to review and reduce length of stay where it is considered that a placement is no longer appropriate. Across Cheshire and Merseyside Key Workers have been fully recruited which is a requirement of the programme, and an Intensive Support Function has been commissioned.

1.2.3.8 Quality

	Latest performance					Year to Date performance			Comparison to England	
	Target	By when	Latest position	Period		YTD performance	Period		England Average	
Quality										
HCAI - MRSA (all cases) rolling 12 month per 100,000 occupied bed days	0	Mar-23	1.50	Mar-23		1.50	Rolling 12 months to Mar-23		2.06	
HCAI - C-Diff (all cases) rolling 12 month per 100,000 occupied bed days	n/a	Mar-23	45.20	Mar-23		45.20	Rolling 12 months to Mar-23		45.01	
Mixed sex accommodation breaches	0	Mar-23	25	Mar-23		391	July 22 to Mar-23		n/a	

Infection Prevention and Control (IPC): There is a renewed requirement to expand on the learning from the pandemic and implement ‘Business as usual’ processes for oversight of IPC, particularly as there has been a resurgence of infections including C Difficile and E Coli rates both regionally and in Cheshire and Merseyside.

Across Cheshire and Merseyside infection rates have risen, particularly for C difficile, E-coli and Klebsiella and there are several providers in Cheshire and Merseyside whose rates are higher than the ambition rates as per standard contract agreed and set.

MSSA rates, although no target set, evidence increased rates. Due to a zero-target applied for MRSA in the contract, several trusts have been impacted by MRSA reported cases.

At a place-based level, IPC oversight has been maintained with providers through performance monitoring via quality schedules and contracting and quality review processes. Any variances in performance is reported into the Quality and Performance Committee.

The National infection prevention and control manual (NIPCM) for England was refreshed in September 2022. It sets out mandatory guidance in NHS settings or settings where NHS services are delivered, and the principles should be applied in all care settings to demonstrate compliance with the 10 criteria of the 'Health and Social Care Act (2008), Code of practice on the prevention and control of infections and related guidance'.

Providers were required to self-assess their compliance with this guidance using the IPC board assurance framework[4] (BAF). In Cheshire and Merseyside, place teams will continue to act as the vehicle for oversight of IPC BAF implementation. Each place is in the process of seeking assurance via CQRM/CQPG process.

A System quality group (SQG) workshop event was held in March 2023 to focus on IPC and Anti-Microbial Resistance (AMR) in Cheshire and Merseyside with leaders to call to action to address AMR through preventing and limiting infections and reviewing prescribing practices. The governance architecture for IPC and AMR Board will be prioritised in 2023-24 and there will be renewed focus on quality schedules ahead of implementation and IPC oversight of compliance will form part of this workplan for 2023-24.

1.2.3.9 Community and Primary Care

	Latest performance					**Year to Date performance**			**Comparison to England**	
	Target	**By when**	**Latest position**	**Period**		**YTD performance**	**Period**		**England Average**	
Community and Primary Care										
The number of personal health budgets in place at any point of the year.	7,719	Q4 22/23	8,087	22/23		8,087	2022-23		n/a	
Count of 2-hour UCR first care contacts delivered within reporting quarter	7,447 Q2, 7,612 2022-23 Ave	Mar-23	4,610	Q4 22/23		3,606	Qtr average 2022-23		n/a	
Children waiting less than 18 weeks for a wheelchair	92%	Mar-23	85.00%	Q4 22/23		85.00%	Q4 2022-23		78.60%	
Number of appointments in General Practice	1,213,064.75 (Ave 2022-23) 1,354,639 (Nov-22)	Mar-23	1,363,560	Mar-23		1,269,842	Ave July to Mar 23		n/a	

[4] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C1501-infection-prevention-control-board-assurance-framework-september-2022.pdf

The number of extended access appointments booked excluding did not attends	58,567.5 (Ave qtr) 58,893 (Qtr 2)	Sep-22	39,725	Q4 22/23		39725	Q4 2022-23		n/a	
The number of people discharged by location and discharge pathway per month	12,314	Oct-22	11,403	Mar-23		94,991	July to Mar-23		n/a	
Hospital discharge pathway activity - pathway 0	10,612	Oct-22	10,037	Mar-23		83,304	July to Mar-23		n/a	
Hospital discharge pathway activity - pathway 1	783	Oct-22	592	Mar-23		4,821	July to Mar-23		n/a	
Hospital discharge pathway activity - pathway 2	399	Oct-22	373	Mar-23		3,506	July to Mar-23		n/a	
Hospital discharge pathway activity - pathway 3	520	Oct-22	401	Mar-23		3,360	July to Mar-23		n/a	
The number of patients that the virtual ward is able to simultaneously manage	1,578.75 (Ave Qtr) 1,085 (Q4)	Mar-23	330	May-23		330	May-23		n/a	
Number of patients waiting at a point in time aggregated for a, in scope CYP and b, in scope Adult services	789,127 (2022-23 total) 157,638 (Q2)	Sep-22	56,584	Mar-23		56,584	Mar-23		n/a	
Number of CYP (0-17 years) on community waiting lists per system	310,954 (2022-23 total) 62,806 (Q2)	Sep-22	15,914	Mar-23		15,914	Mar-23		n/a	
Number of Adults (18+ years) on community waiting lists per system	478,173 (2022-23 total) 94,562 (Q2)	Sep-22	40,670	Mar-23		40,670	Mar-23		n/a	

Social Prescribing and Link Workers: Each Primary Care Network across Cheshire and Merseyside can recruit staff from the Additional Roles Reimbursement Scheme. These staff include social prescribers and link workers, and many of the

Primary Care Networks across Cheshire and Merseyside have recruited these vital posts. Many people who attend a GP practice have needs that are much wider than purely a physical or mental health condition. The health condition can be a result of a social need, for example, people struggling with debt often find themselves with anxiety or depression due to the stress of the situation, people who are feeling low may be so because they are struggling with loneliness. While treating and managing the health condition is essential, unless the underlying cause is addressed, the health condition cannot fully be addressed as it is likely to recur. The role of the social prescriber and link worker is to address needs where people have a social need, such as debt advice, access to community groups etc. They will also take on the role of linking the resident to the various services, helping them to navigate their way around a complex health and care system. These roles not only support the residents in accessing all services they need but they also support clinicians by freeing up clinicians' time to address the clinical need, while the social prescribers and link workers manage the social need and access to other services.

Appointments in general practice and extended access: Appointment activity remains higher than the same pre-pandemic period. The mix of appointments across Cheshire and Merseyside however shows that face to face appointments, are overall slightly lower than pre-pandemic but there has been a relative increase in telephone appointments. Appointment data is reported and overseen at the System Primary Care Committee (bimonthly) where assurance is given on actions to support this at place and corporate level. Enhanced Access is in place across NHS Cheshire and Merseyside and adding much needed extra capacity in respect of appointments.

Continued development of Urgent Community Response: The Urgent Community Response service in Cheshire and Merseyside has seen a month on month increase since April 2022 and this is expected to continue into 2023-24. It is expected that Urgent Community Response services across Cheshire and Merseyside will reach 3,820 patients per quarter by Q4 of 2023-24, compared to 3,395 in Q2 of 2022-23 (baseline). In addition, it is expected that at least 70% of referrals will continue to be met within two hours.

Increase the delivery of Virtual Wards: Over the course of 2023-24 it is planned that the virtual ward bed capacity will be increased on a phased basis from 525 to 899, and that utilisation of this capacity will increase from 65% to 80%. Currently the focus of Cheshire and Merseyside virtual wards is on respiratory, frailty, heart failure and cancer. As the service matures beyond the 2023-24 planning cycle it is expected that virtual wards will be used increasingly for admission avoidance as well as early supported discharge, and that the model will extend from a predominantly non-elective model to increasingly playing a part in the elective care pathway. As part of this there will be continued work to increase referrals into virtual wards.

Community Waiting times: The overall number of patients awaiting a community appointment has reduced during 2022 from 66,037 in April 2022 to 56,587 in March 2023. Further work is being taken forward through the mental health and community service provider collaborative with all provider organisations working together to share best practice and provide mutual aid. Wheelchair services for both Adults and

Children are a particular area of focus with increasing referrals and a rise in the number of patients on the waiting list.

The NHS Cheshire and Merseyside Joint Forward Plan 2023-2028 and Operational Plans (2023-24) reflects the areas of performance where improvement is needed with detailed plans developed to support recovery.

Case Study: Knowsley Respiratory Service

Knowsley's Respiratory Service offers face-to-face Consultant clinics and remote reviews with spirometry being offered in clinic across the week.

The Rapid Response Service continues to provide timely reviews and treatment, preventing hospital admission.

This has been further enhanced by the introduction of the respiratory car in partnership with North West Ambulance Service (NWAS) achieving over 50% of patients reviewed being kept safely at home. Specialist nurses/In-reach nurse based in St Helens and Knowsley Hospital Trust review patients in the EDs and support early discharge, reducing pressure on much needed hospital beds.

The service, in collaboration with Mersey Care and St Helens and Knowsley Hospital Trust, has also continued to provide the COVID-19 virtual ward and NHS COVID-19 Medicine Delivery Unit's to offer neutralising monoclonal antibodies (nMABs) and antivirals for non-hospitalised patients at higher risk of admission. These services have continued to deliver impressive results into the first quarter of 2022-23.

1.2.4 NHS Oversight Framework

The NHS Oversight Framework aligns to the priorities set out in the 2022-23 priorities and operational planning guidance and the legislative changes made by the Health and Care Act 2022, including the formal establishment of Integrated Care Boards.

The purpose of the NHS Oversight Framework is to ensure the alignment of priorities across the NHS and with wider system partners, identify where Integrated Care Boards and/or NHS providers may benefit from, or require, support and provide an objective basis for decisions about when and how NHS England will intervene.

NHS England has, upon establishment of Integrated Care Boards on 1 July 2022, allocated all Integrated Care Boards and Trusts to one of four 'segments'. This segmentation is determined by assessing the level of support required based on a combination of objective criteria and judgement. Upon establishment NHS Cheshire and Merseyside was allocated to segment 3. This is defined as there being:

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

Quarterly review meetings are held with NHS England. Following the most recent meeting held in January 2023, NHS England confirmed to NHS Cheshire and Merseyside that it was assured that NHS Cheshire and Merseyside has a good understanding of the system's position in terms of data, finances, performance and delivery. This provides a foundation on which to build transformation, improvement and develop new ways of working. NHS England has also committed to developing exit criteria with NHS Cheshire and Merseyside to clarify what steps are required to deliver an improvement from segment 3 to segment 2.

The six oversight themes consist of:

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

A set of high-level oversight metrics, is collected and reported at Integrated Care Board and Trust-level, aligned to these themes. There is a significant degree of overlap between the oversight metrics, summarised on the following pages, and the NHS Constitution standards and 2022-23 operating plan targets detailed in the performance narrative above.

- The list of NHS Oversight Framework Metrics showing Cheshire and Merseyside performance, for the latest reporting period available, can be found in Appendix 2 on page 158. NHS Cheshire and Merseyside fell within the highest performing quartile (top 25%) for six metrics, the interquartile range for 39 and were rated as being in the lowest performing quartile (bottom 25%) for 23 metrics, these 23 metrics fall under the following categories: GP appointments per 10,000 weighted patients: although the figure to February 2023 was 3,970 this is higher than the pre-Covid level of 3,458.4.
- Elective care: 52, 78 and 104 week waits – as detailed in performance analysis above.
- Cancer performance: As detailed in performance analysis above.
- Diagnostics activity levels (Physiological measurement): Overall diagnostic metrics are in the interquartile range and better than the England average. Imaging activity at Integrated Care Board sub-locality level is in the highest performing quartile, however activity levels are relatively lower for other tests.

- Learning disability and/or autism inpatients per million head of population: As detailed in performance analysis above.
- Healthcare acquired infections: As detailed in performance analysis above.
- Antimicrobial resistance – prescribing of antibiotics in primary care: As detailed in performance analysis above.
- Diabetes:
    - NHS Diabetes Prevention Programme (NDPP): The Programme was significantly affected by the pandemic, a robust recovery programme has been implemented across the system to recover referrals to pre-pandemic levels and improve uptake of both face to face and digital courses. All Primary Care Networks have been offered funding to improve referral rates, which many have taken up or are in the process of taking up. As more areas implement the plan the level of referrals will improve over the course of 2023-24.
    - Proportion of diabetes patients that have received all eight diabetes care processes: Delivery of the eight Care Processes was also affected by the pandemic, recovery plans commenced towards the end of 2022-23 with a focus on seeing all adults with Type 1 and Type 2 diabetes through annual reviews, as well as opportunistically, to ensure the specific health checks have been completed.
- Sickness absence: NHS trusts All Staff Absences as of 28 March 2023 is 5.2% which is above the national average of 4.4%. Sickness rates in Cheshire and Merseyside Community and/or Mental Health trusts have a higher sickness absence rate as of 28 March 2023, with a range between 6% - 8.6%.
- Cheshire and Merseyside Workforce Priorities continue to focus on actions Promoting Health and Wellbeing:
    - Ensuring appropriate health and wellbeing support for all staff.
    - Ensuring a good working environment.
    - Focussing on retention.
    - Preventing burnout.
    - Ensuring appropriate supervision and preceptorship is available.
- Direct patient care staff in GP Practices and PCNs per 10,000 weighted population: The latest data shows that the number of DPC staff in Cheshire and Merseyside improved from 3.839 per 10,000 weighted population in Quarter 1 (Q1) 2022-23 to 5.264 in Q3. Recruitment continues with the aim of achieving the interquartile range by Q1 2023-24.
- Mental health – IAPT access rate: Access rates for Talking Therapies also remain significantly below target and plans to address this have been developed as part of 2023-24 operational planning processes.
- Neonatal deaths per 1,000 live births: The North-West Neonatal Operational Delivery Network (NWNODN) have oversight of neonatal mortality within the region. Deaths occurring in neonatal units across the North-West (NW) are captured through the Badgernet system. All neonatal unit deaths, deaths occurring on delivery suite and deaths in a hospice where a baby is discharged

directly from the neonatal unit are reviewed in locality clinical effectiveness group (CEG) meetings. CEG reviews are then shared with Child Death Overview Panels (CDOP) around the region to support the child death review process. Mortality rates for neonatal services in the NW are reviewed quarterly through the NWNODN dashboard and where any flags are noted and units are requested to provide internal assurance regarding review, themes and learning. Where mortality flags continue to be raised a NWNODN supported external review may be undertaken. All data regarding neonatal death is reviewed through the NWNODN Senior Management Team meetings. MBRRACE data for neonatal death includes any live born baby >24/40 that dies within 28 days of life, irrespective of place of death or cause of death.

- All outliers for Cheshire and Merseyside have been identified and cases reviewed. The NWNODN will continue to monitor mortality rates as per the NWNODN mortality review process. This data will be shared quarterly with LMNS Safety and concerns groups to triangulate data and identify themes across maternity and neonatal services.
- Two-hour Urgent Community Response: Performance is 76.7% and therefore exceeds the target of 70%.
- Access rates to community mental health services for adults and older adults with severe mental illness: For wider context please see performance analysis under Mental Health above.
- Proportion of diabetes patients that have received all eight diabetes care processes:
- Percentage of beds occupied by patients who no longer meet the criteria to reside: For wider context please see performance analysis under urgent care.
- Older Adult Acute LoS over 90 days (Mental Health): Extended length of stay has a been challenge throughout 2022-23 as a result of delays accessing appropriate support when patients are Clinically Fit and Ready for Discharge. Issues have been escalated via Multi Agency Discharge Events, A&E boards, economy wide meetings, and more recently with NHS England discharge meetings and via the Integrated Care Board System Control Centre.

See Appendix 2 – NHS Oversight Framework: Organisational detail

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1.2.5 Health and Care Partnership Strategy

NHS Cheshire and Merseyside played a key role in the development of an interim Cheshire and Merseyside Health and Care Partnership (HCP) Strategy[5], which was published in February 2023 ahead of a period of related public and stakeholder engagement.

Building on ever-closer collaboration, not least in response to the COVID-19 pandemic, health partners and local authorities have now come together with wider system partners to form Cheshire and Merseyside Health and Care Partnership – our Integrated Care Partnership.

The Health and Care Partnership is moving towards operating as a statutory committee - consisting of health and care partners from across the region and provides a forum for NHS leaders, local authorities and other key organisations to come together, as equal partners, and take collective action.

A vital role of the partnership is to assess the health, public health and social care needs of Cheshire and Merseyside and to produce a strategy to address them – thereby helping to improve people's health and care outcomes and experiences and ensuring we reduce variation across our communities. The interim strategy describes the collective work programme across our whole system, comprising the nine Places of Cheshire and Merseyside, which are co-terminous with our local authorities. The strategy complements the nine local Health and Wellbeing Strategies which focus on the local needs of that population.

By working in partnership, health and care organisations across Cheshire and Merseyside will be better supported to combine our assets to improve efficiency and reduce duplication. By working across Cheshire and Merseyside we can ensure that we learn from each other and adopt what's working well to collectively improve.

The core membership of Cheshire and Merseyside Health and Care Partnership includes:

- NHS Cheshire and Merseyside
- Local authority partners
- Ambulance Service
- Police
- Fire and Rescue Service
- Voluntary, community and faith sector
- Local Enterprise Partnership
- Primary care

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

- Provider collaboratives
- Social care providers
- Adult social care
- Children's services
- Public health
- Carers
- Housing
- Healthwatch
- Education

1.2.6 Transformation programmes

NHS Cheshire and Merseyside provides funding, programme coordination and delivery support to an extensive range of transformation programmes across Cheshire and Merseyside[6] to support achievement of the Health and Care Partnership and Integrated Care Board strategic objectives. In 2022-23 more than £5m was allocated to these.

All programmes are now well established, with the ability to deliver at pace, and there is strong evidence of programme delivery and benefits realisation against funding received in 2022-23 including but not limited to:

- 'Beyond' has reached more than 9,700 children and young people, families and professionals across all nine Places, with a range of benefits including a 40% increase in children and young people on Continuous Glucose Monitoring in Cheshire and Merseyside.
- Our Cardiac Board has worked with Local Authorities and local public health teams to ensure that all nine Places now have a 'Well Me' Blood Pressure Kiosk, which have collectively had more than 8,000 users – empowering more people to take control of their own health and wellbeing.
- 'Early detect, early protect' Digital toolkit launched to support frontline staff in encouraging more people to get screened and receive early treatment for cancer.
- Diagnostics Imaging have secured £20m of additional investment for Cheshire and Merseyside for imaging equipment, liaising with the regional and national teams, supporting trusts with procurement and – via collaborative working – delivering savings of c£300,000.
- Diagnostics Pathology have saved more than £1.35m in 2022-23 through collaborative procurement and renegotiating contracts.

[6] https://www.cheshireandmerseyside.nhs.uk/your-health/our-programmes/

- Medicines Optimisation is on course to maximise delivery of medicines related savings and efficiency projects across Cheshire and Merseyside with a potential value of £10m-£12m in recurrent savings across five core projects, with a further two in development.
- Mental health programme has delivered a single model of care for mental health crisis care (FRISS) currently being rolled out with three new mental health ambulances being procured nationally due for delivery by quarter 3 in 2023-24.
- Population Health Management and Prevention Programme have developed a range of programmes including having co-developed the All Together Active strategy with local stakeholders to support consistent sub-regional approaches to increasing physical activity. Some of the contents of wider population health work programme are described in the Champs section lower down in this report.
- Respiratory Network have focused on establishing community respiratory diagnostic services models to double testing capacity to 5,000 annually.
- Women's Health and Maternity Programme have expanded patient choice and improved care continuity for women in pregnancy, specifically those at higher risk and with greater need from Black and minority ethnic communities (38%) and in areas of high deprivation (28%).

Case Study: Warrington Together's Place-based partnership

Warrington Together has developed a clear delivery framework that provides assurance, risk management and delivery oversight across the borough.

All groups are in various stages of development and the Warrington Together Development Team are leading on and coordinating activity.

The plan to deliver the ambition and priorities as outlined in the Health and Wellbeing Strategy is owned by the Warrington Together Partnership Board (WTPB) which has representatives from all partners across Warrington, including Healthwatch and a representative from the Voluntary, Community, Faith and Social Enterprise Sector.

A robust action plan is in place, which also includes the actions to deliver against the Place Development Framework to move Warrington from Established to Thriving.

Some examples of partnership working under the plan are:

- The Warrington No Wrong Door programme, which is a pioneering way of working across multiple partners to provide support to children and young people on the edge of the care system.
- A new Health and Social Care Academy, which aims to address skills gaps in the local area by training the next generation of health and social care professionals as well as upskilling those currently working in these sectors
- The multi-partner Urgent Community Response (UCR) team has worked closely with a local technology provider to implement a system that enables 999 call handlers to divert calls directly into UCR to prevent avoidable hospital attendances and admissions.

1.2.7 Digital and Data Strategy

Cheshire and Merseyside's Digital and Data Strategy[7] - launched in early 2023 - describes our ambition to improve the health and wellbeing of our region right now and into the long term by weaving our digital and data infrastructure, systems and services throughout the pathways of care we provide.

This requires 'levelling up' of our digital and data infrastructure through investment where this is most needed to improve outcomes for individuals and our population as a whole. We must address the significant inequalities so clearly faced by parts of our population and ensure we successfully support all we serve.

Via technology, we are developing increasingly sophisticated ways of understanding the health and care needs of our population and we are committed to turning 'intelligence into action' to help bring focused and meaningful interventions to those who most need it most.

Helping those in greatest need helps to 'turn the dials' to improve health and care outcomes of our population in an equitable way.

Our Digital and Data Strategy must look to respond to the changes we see and futureproof the health of our population by staying ahead of need.

As we invest into 'levelling up' our digital and data systems and relentlessly drive 'intelligence into action', we will deliver high quality, safe and equitable services that underpin the health, wellbeing and independence of our whole population both now and into the future.

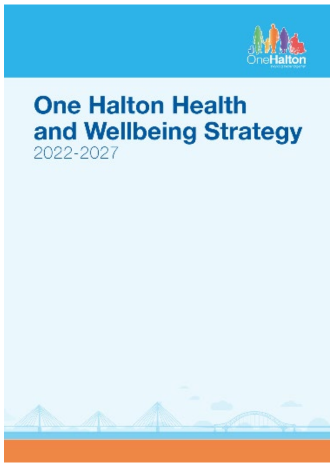
Turning intelligence into action

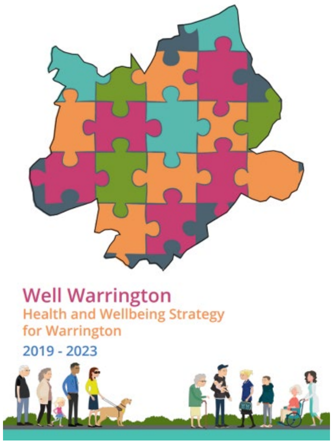
Combined Intelligence for Population Health Action (**CIPHA**) is a population health management platform that collates patient-level data for Cheshire and Merseyside patients to produce dashboards and provide secure data access. CIPHA is aimed at improving the health of our entire population by delivering actionable dashboards.

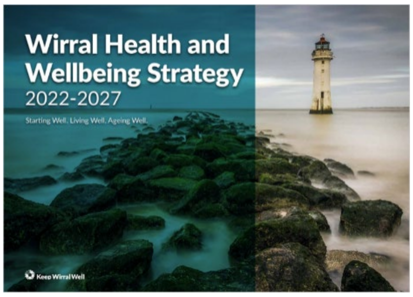
Our Tier 2 Population Health Data Sharing Agreement underpins the CIPHA operating model and has been signed by 400 data controllers across Cheshire and Merseyside, including GP practices, Local Authorities, social care, community and mental health care providers.

[7] https://www.cheshireandmerseyside.nhs.uk/about/digital-and-data-strategy/

1.2.8 Summary Health and Wellbeing Strategies / Place plans







The NHS Cheshire and Merseyside 'Place' teams have continued to work collaboratively with partners in each of our nine places to contribute to the Joint Strategic Needs Assessment identifying the health and wellbeing needs of the population, both now and in the coming years.

Former CCGs performed a key role in helping to shape their local Joint Health and Wellbeing Strategy and NHS Cheshire and Merseyside has continued to be represented on each of the place Health and Wellbeing Boards and involved in updating and refreshing a number of the strategies.

Place-based partnerships are established in each of our nine places and have developed Place Plans which are informed by national, regional, and local objectives and priorities: NHS Long Term Plan, NHS Planning Guidance, NHS Cheshire and Merseyside strategic objectives, Joint Health and Wellbeing Strategy and local place strategies. The supporting governance and delivery structures established in each Place provide the infrastructure to deliver on these local priorities.

NHS Cheshire and Merseyside has consulted with each Health and Wellbeing Board in reviewing delivery to date and developing the Joint Forward Plan. The Health and Care Partnership strategy together with the local Health and Wellbeing Board strategies reflect a shared delivery plan encompassing both local priorities delivered at place and those priorities best delivered at system-level.

1.2.9 Delivering on our statutory duties

1.2.9.1 Introduction

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

1.2.9.2 Improving quality

NHS Cheshire and Merseyside views the quality and safety of the services it commissions as its top priority and continues to strengthen its overarching quality governance framework to ensure people in Cheshire and Merseyside are able to access services that are safe, effective and positively experienced.

NHS Cheshire and Merseyside has developed a ‘primacy of Place’ model to maintain oversight of quality as close to the respective local population as possible. Each of the nine Place-based areas have established routes to connect with local partner organisations to discuss and agree how services can be accessed and improved. These local processes, and the information that is generated, is shared via the Quality and Performance Committee, a sub-committee of NHS Cheshire and Merseyside.

NHS Cheshire and Merseyside reviews a wide range of information to assess the quality of services, including Friends and Family Test (FFT) information, Healthwatch feedback, Care Quality Commission (CQC) inspection reports, freedom to speak up (FTSU) and survey data. We also continue to develop our overarching performance and quality dashboard that acts as the central source of quality and performance data.

Each of the nine Places has a dedicated quality team who provide the oversight and monitoring of quality in each of the individual places. This is shared across NHS Cheshire and Merseyside for lessons learnt or areas of good practice. The teams are skilled in not just quality assurance but also quality improvement, as we constantly strive to improve quality in all we do.

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

Examples in 2022-23 include:

- Work in Liverpool to remove barriers when discharging people from hospital into a residential care home placement. This includes the development of partnerships with local NHS organisations and the independent sector to support access to a temporary workforce resource.
- Work in partnership with local NHS, Local Authority, and independent organisations in Warrington to improve the care of those residing in independent mental health hospitals within the local area.
- Work to ensure there are robust systems and processes in place to support organisations in improving their System Oversight Framework ratings by jointly assessing the quality improvement work undertaken and ensuring its positive impact for both staff and service users.
- Quality improvement work presented thematically via NHS Cheshire and Merseyside's System Quality Group (SQG). This forum has led to a series of system-level quality improvement actions generated to improve the quality of care in residential settings and maternity triage and risk assessment. Actions plans are produced from SQG in order to monitor and evaluate impact.
- Quality & Performance committee risks as well as those via System Quality group will be used to inform the Regional Quality Group. There is a robust process of Place and Corporate risk registers which are monitored and managed.
- The implementation of the Patient Safety Incident Response Framework (PSIRF) in Autumn 2023 will provide effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This will be triangulated with complaints, compliments and freedom to speak up data to form a well-rounded view of services in order to improve safety and quality.
- Development of 'gateway' work in Wirral Place to enhance the work of a multi-agency 'preventative' model of care for children with mental health needs, focusing on integrated proactive care at Place to identify and support children and young people before they reach a crisis.

NHS Cheshire and Merseyside continues to focus on work to improve access to diagnostic, cancer and planned care services in line with national standards - with

December 2022 diagnostic performance equal to the north-west performance and better than the overall performance for England.

Based on December 2022 data, NHS Cheshire and Merseyside has performed better than both regional and national benchmarks for the percentage of patients referred for cancer treatment by their GP who wait less than 62 days for treatment to start but recognise that ongoing work is needed to further improve.

NHS Cheshire and Merseyside continues to reduce the backlog of those patients awaiting planned care in line with national trajectories but again recognise the importance of going further and faster to ensure waiting times return as soon as possible to pre-pandemic levels.

The staff survey provides data used to support delivery of the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) and their associated action plans. The Cheshire and Merseyside Staff Survey 2022 results showed there has been improvements in three of the four sub themes for 'We are Compassionate and inclusive', with a significant difference in the number of people who felt their organisation respects individual differences.

There is ongoing monitoring of diversity in NHS Cheshire and Merseyside in the senior leadership tiers at Board, Executive and succession lines of senior leadership body. Tackling workforce inequalities in Year 1 of the Integrated Care Board lifecycle will include development of cultural competence across the organisation to drive a Just culture and Inclusive leadership development to further improve staff experience and opportunities.

Case Study: Website launched to help start conversations about cancer screening

A new website to support healthcare and community professionals to start conversations about screening for breast, bowel and cervical cancers with people living in Cheshire and Merseyside was launched in 2022-23.

Every year, around 16,000 people are diagnosed with cancer across Cheshire and Merseyside and 7,000 lose their lives as a result of the disease. But by promoting informal conversations about how screening works, Cheshire and Merseyside's Directors of Public Health, working with the Cheshire and Merseyside Cancer Alliance, hope to bring those numbers down.

With a detailed information toolkit and range of promotional resources, Early Detect Early Protect has been created to educate and empower everyone from GPs to community nurses, community professionals and volunteers to start earlier conversations about screening with the people they see every day.

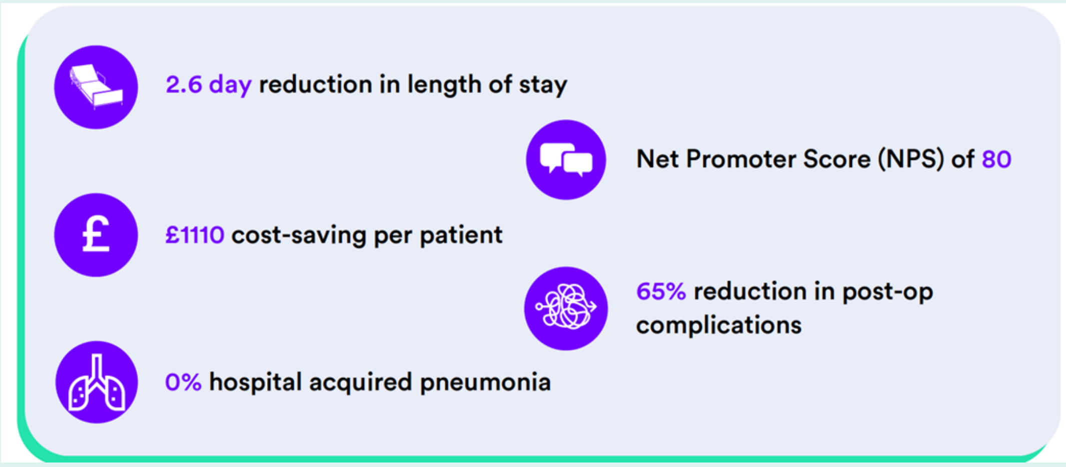
Case Study: Transforming waiting lists into 'preparation lists'

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

How it works:

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

Findings for the first 100 members to have undergone prehabilitation support indicate a significant impact on the reducing rates of post-operative complications as well as a marked reduction in the length of hospital stay:



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

Case Study: Improving access to bowel screening

The St Helens Quality team is leading a North West pilot to improve access and uptake of bowel screening for people with a learning disability through the active use of 'flagging'.

A flag will enable providers working along the pathway to be aware that an individual eligible for bowel screening has a learning disability and will allow providers to put in place any appropriate support or reasonable adjustments that may be required along the pathway from initial invitation to treatment. This project will enable people with a learning disability to receive appropriate support to make an informed choice about bowel screening and any treatment required.

1.2.9.3 Safeguarding

As with all NHS bodies, NHS Cheshire and Merseyside has a statutory duty to ensure arrangements are in place to safeguard, protect and promote the welfare of children, young people and adults at risk of abuse and harm. This 2022-23 update provides an overview of how NHS Cheshire and Merseyside has discharged its statutory duties.

The Children Act (1989 / 2004), Working Together to Safeguard Children (HM Government, 2018) and Care Act 2014 underpin the work of the Safeguarding and Looked After Children Teams which supports NHS Cheshire and Merseyside in discharging its duties for children and families living across Cheshire and Merseyside. Section 11 of the Children Act (2004) places a legal duty on all health organisations, including Integrated Care Board s to ensure that, in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

NHS Cheshire and Merseyside has Place-based safeguarding teams covering each of the region's nine Places. The Safeguarding Service is accountable to the Executive Director of Nursing and Care. The team also includes Associate Directors of Quality and Safety Improvement, Heads of Safeguarding, Designated Nurses and Professionals, Named GPs, Designated Doctors for Child Protection, Child Death and Children in Care and safeguarding administrators. There is a suite of Integrated Care Board safeguarding policies available to all staff on the staff internet and a robust Training Need Analysis developed and Integrated Care Board and multi-agency safeguarding training implemented for NHS Cheshire and Merseyside staff members, as per intercollegiate guidance.

NHS Cheshire and Merseyside governance oversight of our Integrated Care Board safeguarding statutory duties are monitored via the Integrated Care Board System Oversight Board, which is chaired by the NHS Cheshire and Merseyside Director of Nursing and Care and reports to the Quality and Performance Committee.

The Integrated Care Board Designated Professionals Network, meets every six weeks and is attended by the Designated and Named professionals to share best practice approaches, enable peer supervision and embed local, regional and national safeguarding learning into our Integrated Care Board practice. This network will then feed into the planned NHS Cheshire and Merseyside Safeguarding Oversight Group.

The Safeguarding Oversight Group will have delegated responsibility from the System Oversight Board which sets the NHS strategic context for these our statutory functions: Child death overview; safeguarding children; children in care and adults at risk. This Safeguarding Oversight Group will provide assurance, scrutiny and exceptions about NHS practice for these functions in each of the nine Places, reviewing associated learning, health inequalities or inequities within safeguarding or children in care. against the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (SAAF). This group will provide a report to the Oversight Board on how NHS Cheshire and Merseyside is meeting its statutory duties against these functions.

NHS Cheshire and Merseyside gains assurance that its commissioned health providers are complying with statutory safeguarding duties through the Cheshire and Merseyside Safeguarding oversight of delivery against the Commissioning Standards for Children, Looked After Children and Adults. This includes our all-age Continuing Care providers, who provide care packages under the NHS contract. Working alongside our contract and continuing health care teams, the safeguarding teams monitor performance of health providers to ensure effective safeguards are in place to ensure the highest possible standards of care to our children, young people and adults at risk.

During 2022-23, the Safeguarding Service has gained assurance of commissioned NHS trusts using contract monitoring via quality schedules, safeguarding Key Performance Indicators, NHS England commissioning standards, action plans and self-evaluation frameworks, based upon the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework which was updated in July 2022.

Safeguarding is a shared responsibility across the health economy and wider multi-agency partnership. NHS Cheshire and Merseyside's teams help drive improvements through local and regional partnership working to ensure responsive safeguarding practice to address national and local priorities and influence safe and effective care and commissioning.

Additional assurance processes include contracts, learning from Serious Case Reviews (SCRs), Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHRs), Learning Disabilities Mortality Reviews (LeDeR), Child Death Overview

Panel Cases, Case Reviews, incidents and complaints. To support the submission of submission of evidence to the NHS England Safeguarding Assurance Template, assurance is further sought by speaking to staff, reviewing incident reports, rapid reviews and involving providers in Serious Incident Review Panels, audits and via attendance at Provider Safeguarding and Quality Committees.

As a statutory partner alongside Local Authorities and the Police, the safeguarding service continues to promote effective joint working across the Integrated Care System. NHS Cheshire and Merseyside has representation on each of the local Safeguarding Children Partnerships and Safeguarding Adults Boards across our nine Places as well as at several statutory partnerships including Child Death Overview Panels, Corporate Parenting Boards, Channel Panels, Multi-Agency Public Protection Arrangements Boards, Domestic Abuse Partnership Boards and Community Safety Partnerships.

There are wider Integrated Care System partner representatives at these groups including, NHS providers, Criminal Justice Services, Office of the Police and Crime Commissioner, Education, Healthwatch and VCSE services including representatives from our local engagement groups such as ‘Disability Positive’ and ‘Cheshire Without Abuse’ as examples. These groups continue to be key to ensuring effective community and citizen participation in the work of the wider Integrated Care System to safeguarding our residents across Cheshire and Merseyside.

Each of our nine Places have system wide strategies in place to ensure the voice of the child is heard locally. For example ‘My Voice’ is Cheshire East’s Council for Cared for Children and Care Leavers. Children and young people have the opportunity to have their say and make positive changes about services that affect their lives. They are also able to make new friends, take part in fun activities and work closely with professionals. In Sefton there is the Sefton Youth Charter and Youth Voice which gives children and young people an arena to use their voice and opinions to shape the support they receive.

NHS Cheshire and Merseyside aims to develop a Child Voice Strategy for safeguarding and children in care, to be inclusive, respectful, and centred on co production and the best interests of the child or young person. It is essential to create an environment where children feel empowered, valued, and heard in all matters concerning their wellbeing and safety.

As an Integrated Care Board, we have a statutory and crucial role in child death overview and this is gained through our Safeguarding Children Partnerships Child Safeguarding Practice Review processes as well as our local Child Death Review Processes. Across Cheshire and Merseyside we remain a statutory partner within the Pan Cheshire and Pan Merseyside Child Death Overview Panels (CDOP) where we can learn lessons from child deaths, in order to improve the health, safety and wellbeing of other children and look at preventing other child deaths and share this across our Integrated Care System for wider learning.

The purpose of the reviews undertaken is to understand the circumstance, factors and themes contributing to the deaths of children under 18 years of age and take into account health issues or inequalities which may have been a factor in the death, for example if a child with a learning disability had died, CDOP ensure the LeDeR is linked in with the CDOP review. This is a critical aspect of ensuring the safety and wellbeing of children with learning disabilities and/or autism, to identify any areas for improvement in their care and support. Our panels ensure ongoing, multi-agency review of the child death review and LeDeR processes. This includes regularly reviewing the outcomes and impact of the implemented recommendations and making any necessary adjustments to ensure continuous improvement in the care and support provided to children with learning disabilities. By addressing these key elements, Integrated Care Boards can provide assurance that child death review, particularly the LeDeR, is conducted effectively, and that the recommendations arising from these reviews are implemented, across the system to enhance the safety and wellbeing of our children with learning disabilities.

The Safeguarding Service ensures learning from national and local reviews, as well as independent enquiry recommendations, are disseminated in a variety of ways including: safeguarding training, multi-agency 'lunch and learn' safeguarding sessions, Critical/ Serious Incident Groups, multi-agency statutory review / learning events held by our Place-based Partnership Boards. As well as learning events held by NHS England and providing the NHS Cheshire and Merseyside System Oversight Board reports for internal assurance.

The Safeguarding Service will continue to support delivery against safeguarding responsibilities and statutory functions and to develop the key safeguarding priorities for 2023-24 so that we remain responsive, creative, flexible to demands and work positively across the system to support developments and ensure safeguarding process and practice is effective and robust.

Place	Safeguarding Adults Board	Safeguarding Children Partnership
Cheshire East	Cheshire East Safeguarding Adults Board	Cheshire East Safeguarding Children's Partnership (CESCP)
Cheshire West and Chester	Cheshire West and Chester Safeguarding Adults Board	Cheshire West Safeguarding Children Partnership
Halton	Halton Safeguarding Adult Board	Halton Children and Young People Safeguarding Partnership

Place	Safeguarding Adults Board	Safeguarding Children Partnership
Knowsley	Knowsley Safeguarding Adults Board	Knowsley Safeguarding Children Partnership
Liverpool	Liverpool Safeguarding Adults Board (LSAB)	Liverpool Safeguarding Children Partnership (LSCP)
Sefton	Sefton Safeguarding Adults Board	Sefton Local Safeguarding Children Partnership
St Helens	St Helens Safeguarding Adult Board	St Helens Safeguarding Children Partnership
Warrington	Warrington Safeguarding Adults Board (WSAB)	Warrington Safeguarding Partnership
Wirral	Wirral Safeguarding Adults Partnership Board	Wirral Safeguarding Children Partnership

Case Study: Joint Targeted Area Inspection – Wirral

In December 2022 a Joint Targeted Area Inspection undertaken in Wirral by Ofsted, the CQC and His Majesty's Inspectorate of Constabulary and Fire and Rescue Services.

The inspection looked at how effective local arrangements were to support children and families who require early help support. The inspection focused on the three statutory agencies of the Local Authority, NHS and Police, but also looked closely at the role played by other organisations who support families.

The resulting letter of findings following the inspection was positive and included the following:

“Children and families in the Wirral are benefiting from a broad and generally well-coordinated range of family support and early help services that make a positive difference to their lives.

“Leadership and healthy challenge have enabled the partnership to develop a strong and effective early help offer to children and their families. The partnership has a strong, shared, and often innovative, vision for early help.

“Parents described practitioners as ‘a magic key’ to achieving improvements in their children’s lived experiences. They feel that practitioners are invested in them and show genuine warmth and care.”

1.2.9.4 Special Educational Needs and Disabilities (SEND)

As with all NHS bodies, NHS Cheshire and Merseyside has a statutory duty to comply with the Children and Families Act (2014) and SEND Code of Practice (2015) which provide legislative guidance to ensure a holistic approach is taken to identify the education, health and social care needs of children and young people aged 0-25 years with SEND. Places within Cheshire and Merseyside are required via local area partnerships, to develop appropriate provision, within a spirit of inclusion, to meet the identified needs of their children and young people with SEND to ensure positive experiences and outcomes.

NHS Cheshire and Merseyside has established clear SEND leadership and governance in compliance with recent statutory guidance[8] regarding executive lead roles within integrated care boards, Christine Douglas (Executive Director of Nursing and Care) adopting the Executive Lead for SEND within her portfolio.

Ahead of anticipated further statutory guidance regarding SEND-specific roles, and with significant additional investment, NHS Cheshire and Merseyside has also appointed a Senior Responsible Office for SEND and a Head of SEND post within its corporate structures. These are additional to increased capacity of Designated Clinical Officers (SEND) at Place across Cheshire and Merseyside. These roles will ensure oversight and assurance of consistent, high-quality, SEND practices across NHS Cheshire and Merseyside.

The effectiveness of local area partnerships is assessment via Joint Ofsted/CQC Area Inspection, initially via a round of inspections under the original Area SEND Inspection Framework (2015). New statutory guidance relating to Area Special Educational Needs and Disabilities (SEND) inspections was published on 29

[8]

November 2022 and came into force on 1 January 2023. The guidance comprises of a framework and a handbook.[9]

The new framework places increased focus on the impact that local area partnerships have on the experiences and outcomes of children and young people with SEND. A new ongoing cycle of inspections has been introduced, with the aim of strengthening accountability and supporting continuous improvement across the SEND system. Inspections also evaluate how local authorities commission and oversee alternative provision. The framework sets out the purpose and principles of inspection and the statutory basis, along with the inspection approach, model, frequency and timing.

Three possible outcomes result from the area SEND inspection:

Inspection outcome **Local area partnership's SEND arrangements evidence:**	**Follow-up inspection activity**
Positive experiences and outcomes for CYP with SEND. The local area partnership is taking action where improvements are needed.	• Engagement meetings • Full inspection usually within five years
Inconsistent experiences and outcomes for CYP with SEND. The local area partnership must work jointly to make improvements.	• Engagement meetings • Full inspection usually within three years
Widespread and/or systematic failings leading to significant concerns about the experiences and outcomes of CYP with SEND which the local area partnership must address urgently.	• Engagement meetings • Submission of priority action plan (area SEND) • Monitoring inspection within 18 months of the publication of the full inspection report • Full reinspection usually within three years

[9] https://www.gov.uk/government/news/improving-outcomes-for-children-and-young-people-with-send

The Place of Warrington is the only Cheshire and Merseyside Place to date to undergo inspection under the new framework, with the middle outcome resulting.[10]

Cheshire and Merseyside SEND inspections outcomes to date:

Place	Date of inspection letter	Inspection framework used	Outcome	Next inspection due
Cheshire West	April 2022	2015	No WSOA*	Predicted within the next three years
Cheshire East	April 2018 May 2021 (Revisit)	2015 2015	WSOA WSOA Lifted	Predicted within the next three years
Knowsley	April 2021	2015	WSOA	Within the next three years
Halton	May 2017	2015	No WSOA	Imminent due to date of last inspection
Liverpool	Feb 2019 June 2022 (Revisit)	2015 2015	WSOA WSOA lifted	Predicted within the next three years
Sefton	Dec 2016 June 2019 (Revisit)	2015 2015	WSOA WSOA lifted	Predicted within the next three years
St Helens	March 2018	2015	No WSOA	Imminent due to date of last inspection
Warrington	Feb 2019 Feb 2023	2015 2023	No WSOA Inconsistent	Within the next three years.

[10] https://reports.ofsted.gov.uk/provider/44/80575

Wirral	Dec 2021	2015	WSOA	Within the next three years

Areas with current Written Statements of Action (WSoA), at the Places of Wirral and Knowsley, receive additional scrutiny by NHS Cheshire and Merseyside's SRO and Head of SEND in order to support and challenge progress against improvement plans required to address health-related issues highlighted in the WSoA.

1.2.9.5 Engaging people and communities

This section of the Annual Report sets out how NHS Cheshire and Merseyside has discharged our duty to involve the public in 2022-23.

Following national public consultation, new statutory guidance for working with people and communities[11] was published in July 2022. This guidance is for Integrated Care Boards, NHS trusts and NHS England.

Application of the guidance has supported NHS Cheshire and Merseyside and our partners to work effectively with people and communities in 2022-23 – with the aim of both improving services and meeting our duty to involve the public.

1.2.9.6 Public Engagement Framework

NHS Cheshire and Merseyside's draft Public Engagement Framework[12] was co-produced with Healthwatch and the Voluntary, Community, Faith and Social Enterprise Sector and published in July 2022.

It describes how NHS Cheshire and Merseyside applies the 10 principles in the statutory

[11] https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/
[12] https://www.cheshireandmerseyside.nhs.uk/media/jz1ip34u/cm-public-engagement-framework-draft-101022.pdf

guidance[13] and the approaches and mechanisms that have started to be developed in 2022-23 which will underpin our work with people and communities in 2023-24.

Further Equality Impact Assessment will be carried out by October 2023 to enable NHS Cheshire and Merseyside to do a 'stock-take' and assess the diversity and inclusivity of our work with people and communities. This assessment will inform actions to build further connections and networks to enable increased input from people who experience the greatest health inequalities.

Following Equality Impact Assessment, and by March 2024, people and communities will be involved in a structured process of evaluation and review of our Public Engagement Framework, that informs its update for 2024-25.

1.2.9.7 Early communications approach

The early communications approach for NHS Cheshire and Merseyside and the wider Integrated Care System has been based around the following three key objectives:

- Raising the profile of both NHS Cheshire and Merseyside and the Cheshire and Merseyside Health and Care Partnership:
    - Across and within partner member organisations
    - Across communities of Cheshire and Merseyside to support transparency and enable effective public engagement with and scrutiny
- Maximising proactive opportunities to highlight the benefits of cross-partner, collaborative working in relation to:
    - Tackling / reducing health inequalities
    - Improving patient / resident health, wellbeing, and experience
- Ensuring related media work is appropriately managed – with input from all relevant partners – to help maintain public confidence in local health and care services.

To support the delivery of these objectives a simple core narrative, translated into an animated 'video explainer'[14], has been produced for use by health and care partners.

[13] https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/
[14] https://youtu.be/blapgFKXv0I

1.2.9.8 Citizens’ Panel

In October 2022, NHS Cheshire and Merseyside launched a Citizens’ Panel following an initial recruitment campaign aimed at widening the participation of people and communities representing equality-protected groups and people affected by inequalities.

The purpose of the Citizens’ Panel is to find out what a representative sample of residents think about local issues and services in a cost-effective way. Citizens’ Panel members can choose which activities they want to take part in and opt out of those that don't appeal.

It is essential that we embed the citizens’ voice in the commissioning cycle and strengthen our ability to demonstrate the impact that people’s experiences, insights and aspirations have on our work. Insights collected from our panellists will be triangulated with other sources of data from our Places - such as PALS and complaints data and Healthwatch reports – and used to create insight and intelligence reports.

The Citizens’ Panel complements other types of research, such as in-depth qualitative projects, research with those who don’t use online services and other engagement programmes.

By July 2023, we aim to increase the number of panellists from c700 (March 2023) to more than 1,000 as we build our capacity to involve people from all sections of the community, and not simply those already engaged with health, social care and voluntary sector organisations and groups.

Increasing the participation of young people in our Citizens’ Panel is a key strategic aim. By involving young people, the NHS and its partners can build trust, bring about innovative service improvement and inspire the next generation of health and social care leadership.

By October 2023 we aim to increase participation of 16–20-year-olds in our Citizens’ Panel through a range of methods, in partnership with organisations who have specialist experience of working with young people. We will then connect with this audience to understand their priorities and how they can best be involved in our work.

In 2023-24 the Citizens’ Panel will continue to be used to identify and respond to local priorities and test approaches to involving people and communities in the four key purposes of the Integrated Care System.

1.2.9.9 Engagement on the Health and Care Partnership Strategy and Joint Forward Plan

NHS Cheshire and Merseyside launched a campaign in March 2023 to seek the views of people, communities and partners on the priorities within the Health and Care Partnership's Interim Strategy[15], to inform the development of a Joint Forward Plan.

The aim of the campaign is to gather as many views from people and communities on local priorities, as possible. During 2023-24 this feedback will be responded to and used to develop our approach to working with people and communities.

Following the publication of the Joint Forward Plan forward plan, NHS Cheshire and Merseyside will carry out further public involvement activity during 2023-24 to ensure that its implementation is informed by working with people and communities.

1.2.9.10 Developing the capability and capacity for effective involvement

As part of our duty to involve NHS Cheshire and Merseyside is supporting people and communities to develop their capability and capacity for involvement in the Integrated Care System.

In February 2023, through our Citizens' Panel, we were able to offer the opportunity for panellists to join the NHS Peer Leadership Development Programme. The course promotes the benefits of personalised care, giving people the skills, knowledge and confidence to be able to use their lived experience at a strategic level by being part of discussions where system-level decisions are made.

The course is delivered in bite-size chunks using language that is easy to understand and includes videos with subtitles and transcripts. The programme is free and runs continuously so that people can join at any time. It's delivered online in partnership with an accessible learning platform.

To date 30 people have started the course from across Cheshire and Merseyside with the aim to develop new Peer Leaders - people with lived experience who are committed to working collaboratively with NHS Cheshire and Merseyside (and Integrated Care System partners) to shape and influence how health and care is delivered locally.

By July 2023 at least 50 members of our Citizens' Panel will have been enrolled on the NHS Peer Leadership Development Programme. During the remainder of 2023-24 this target will be extended to more than 100 participants signed up from across our communities.

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

1.2.9.11 Cheshire and Merseyside Lived Experience Network

From July 2023 people undertaking the Peer Leadership Development Programme will be invited (alongside members of the wider community) to provide Lived Experience input to NHS Cheshire and Merseyside governance forums, projects and service change forums.

The group will be made of people who are living with either a mental and / or physical health condition (or as carer) and would like to be part of the decision-making process within Cheshire and Merseyside. Successful candidates will be fully supported in their role and we will ensure that they are able to play a full part at meetings and in discussions and that their views and feedback are heard.

A range of learning and development opportunities will also be developed and made available to members of the network, who will be renumerated in line with the national involvement payments and expenses guidance.

Network members will be encouraged to use a range of methods to get feedback from local people and communities, act as an advocate for the voice of lived experience and engage with a variety of people at differing levels of authority. Their involvement in our work will ensure consistency of how services need to be centred around people's experiences and views.

1.2.9.12 Working with Integrated Care System partners

NHS Cheshire and Merseyside is required to work with other NHS bodies, Local Authorities, Healthwatch and the Voluntary, Community, Faith and Social Enterprise Sector (VCFSE) in discharging its duty to involve the public.

Collaboration and partnership working is about building relationships with organisations and local communities in a way that treats partners equitably and that recognises the contribution that can be made to improving the health and care system.

As part of the development of our Public Involvement Framework, Healthwatch and the VCFSE provided feedback on ways in which partnership working (to meet the duty to involve) can be improved.

In 2023-24 NHS Cheshire and Merseyside will work with Healthwatch to establish a Cheshire and Merseyside-wide forum that:

- Builds stronger relationships with the local Healthwatch network
- Ensures early inclusion of Healthwatch in designing, planning and delivering Integrated Care System involvement activities
- Ensures that the statutory functions, activities and duties of Healthwatch are maximised in planning, designing and delivering quality services
- Insight and intelligence from Healthwatch reports, and 'Enter and View' programmes of work are maximised

- Increases opportunities for community involvement, designed and led by Healthwatch

NHS Cheshire and Merseyside will also work with the Cheshire and Merseyside VCFSE infrastructure organisations to:

- Recognise and use VCFSE infrastructure organisations as a key channel for two-way communication with communities
- Increase public involvement through the extensive reach of VCFSE infrastructure
- Maximise VCSFE insight and data to inform planning and delivery
- Increase opportunities for community engagement, designed and led by VCFSE infrastructure.

NHS Cheshire and Merseyside also has a duty to engage with, and consult with when required, Local Authority health scrutiny functions. Depending on the impact of any proposed changes to any health services, NHS Cheshire and Merseyside engages or consults with any of the nine Local Authority Health Scrutiny Committees across the ICS or via a Joint Health Scrutiny Committee arrangement. Throughout 2022-23 the ICB has continued to engage with each individual Health Scrutiny Committee in each Local Authority area.

During 2022-23 the nine Local Authorities within the ICS agreed to form a standing Cheshire and Merseyside Joint Health Scrutiny Committee[16] which will have the opportunity and authority to take on the nine Authorities' collective statutory responsibility to oversee and scrutinise the operation of the ICS at Cheshire and Merseyside level.

The Joint Committee met on two occasions throughout the 2022/23 period where it heard updates from the ICB on the following areas:

- progress in establishing the ICB and current performance (November 2022)
- development of Place Based Partnerships (November 2022)
- development of the Cheshire and Merseyside ICB Strategy and Five Year Joint Forward Plan (November 2022 and March 2023)
- the transfer of delegated commissioning responsibility to NHS Cheshire and Merseyside by NHS England of primary, secondary and community care dental services (March 2023)
- NHS Cheshire and Merseyside Public Engagement Framework (March 2023).

1.2.10 Summary

Examples of how our Place networks are involving people and communities across Cheshire and Merseyside:

16 https://councillors.knowsley.gov.uk/ieListMeetings.aspx?CId=2391&Year=0&StyleType=standard&StyleSize=none

Place	Activity
Cheshire East	Working with the local Primary Care team to lead on the development of a pack to support asylum seekers who have been placed across hotels and accommodation in Cheshire East to access services. These packs were printed and displayed across public areas of the accommodation and also sent digitally to those people with access to a mobile phone. The council also were able to translate the packs into 18 other languages.
Cheshire West	Cheshire West Place has commissioned Cheshire West Voluntary Action to design a Local Voices Framework (LVF) together with local people with lived experience as equal partners, that follows the key principles of coproduction, as set out in the West Cheshire Compact[17]. The Framework is supporting and enabling the development of transformational relationships, creating an equity between decision-makers, organisational leaders and people accessing services.
Halton	One Halton is a platform for engagement which supports and unites a wide variety of stakeholders. One Halton People and Communities Voice meetings provide attendees from NHS organisations, the Local Authority, VCFSE organisations and patient and public representatives groups (PPGs, Residents Associations) the chance to hear from local decision makers. Guests are invited to speak to attendees, who are then provided with materials for newsletters and social media so that they can return to their own organisations and help us to promote engagement work. Attendees are also provided with questions to take back to their own drop-ins and meetings to seek feedback and patient experience on a chosen topic. It has proven an effective way to engage with groups who might not respond to NHS engagement but will respond to a VCFSE organisation they trust and value. An example includes One Halton's Digital Inclusion Strategy, which was discussed with the group, we provided attendees with materials which promoted the Digital Inclusion survey and asked them to gain feedback and views.
Knowsley	Working closely with Knowsley Local Authority colleagues on The Knowsley Offer - a website[18] giving Knowsley residents access in

17 https://www.livewell.cheshirewestandchester.gov.uk/Information/Compact_Principles_and_Outcomes_Table
18 https://www.knowsleybettertogether.co.uk/theoffer/

	one place to all the information they need on local services available to them including health, care, leisure, community safety, jobs. In addition to providing content for the site with easy-to-read information on urgent care, mental health support and local community services NHS Cheshire and Merseyside has been integral part of engaging the public on the Knowsley Offer with other partners from Knowsley Better Together to ensure a joined up and integrated approach to supporting residents to thrive. This work has gone hand-in-hand with the NHS working more closely with public health to ensure a joined-up approach when communicating health initiatives and awareness to the public.
Liverpool	Between 7 June and 2 August 2022, the NHS in Liverpool ran a public consultation about proposed changes to five Liverpool University Hospitals NHS Foundation Trust (LUHFT) services. Aimed at reducing duplication and improving patient care, the proposals covered breast surgery, general surgery, nephrology, urology, and vascular surgery at the trust. Attracting more than 2,800 responses, the public consultation utilised a range of channels and techniques to gain feedback and meet different communication needs and preferences. This included a questionnaire (available online and in alternative formats), telephone line and a series of virtual focus groups. The proposals were approved in autumn 2022, with feedback from the consultation used as part of the final decision-making process.
Sefton	Sefton has well-established public involvement structures, and this year reviewed its respected engagement and patient experience group terms of reference to ensure it could transition into a key forum for co-production. Led by the Sefton Place team, the newly refreshed People and Communities Group brings together representatives from across health and care to co-ordinate activities and adopt best practice approaches, with the aim of supporting better decisions about service changes helping to shape a sustainable future for the NHS that more closely meets people's needs and aspirations. Examples of work considered by the group include: • Accessing GP practice services – Sefton patients were invited to complete a survey sharing their experiences of using services during the COVID-19 pandemic. Each practice has been assessing its results together with its patient participation group to co-design changes, such as improving telephone and reception processes.

	• Shaping Care Together - an ongoing engagement programme looking to 'futureproof' services across Southport, Formby and West Lancashire. Engagement activity has included online and offline questionnaires, public, patient and staff meetings and in-depth discussion groups.
St Helens	Talkfest is St Helens' way of engaging with as many different people and communities as possible including schools, workplaces, community, partners and third sector and voluntary organisations. As part of its Place-based engagement plan, a winter Talkfest online engagement session was held in December 2022, around themes including cost of living and keeping well during winter. Topics included information around winter viruses, key actions for keeping well during winter, information about the support available and gathering people's views on how to approach winter given increases in the cost of living. Those that attended were able to ask questions, receive resources and take-home key messages that could then be shared within organisations and communities. The session also gave us the opportunity to talk about the range of services available locally and when to use them. This was supported by a BSL video[19] produced for our deaf community.
Warrington	In the summer of 2022, the Warrington Place team supported the five Primary Care Networks (PCNs) to deliver a consultation on their proposals for an upcoming GP Enhanced Access service. Training was provided for PCN staff around the duty to involve, including ideas and suggestions on relationship-building with existing networks and activity. NHS Cheshire and Merseyside colleagues facilitated a task and finish group to support the PCNs to plan the consultation, providing relevant templates and guidance. We supported the PCNs to develop relationships with networks and organisations including: • Warrington Together's People and Communities Voice • PPG Together • Staying Connected (a VCFSE forum run by Warrington Disability Partnership) • Speak Up (a VCSFE forum for people with Learning Disabilities) Weekly reports on the responses were provided so that any gaps could be addressed while the consultation was open. The engagement reach included direct messages to c143,000 patients

[19] https://www.youtube.com/watch?v=2GEEV7_KE5E

	and attendance at more than 30 meetings and drop-ins. Around 7,000 residents completed the survey.
Wirral	Following an OFSTED inspection of Special Educational Needs and Disability (SEND) services in Wirral, a Written Statement of Action was developed and, in particular, the need for a revised Local Offer website. The Local Offer acts as a vital resource for people with Special Educational Needs and Disabilities, parent / carers and professionals to find information on SEND services and to navigate the sometimes quite complex processes. The inspection found that the existing Local Offer in Wirral was not well known and did not provide a usable or effective information resource. As a result, a workstream was established led by NHS Cheshire and Merseyside in partnership with Wirral Council and groups representing children and young people. The focus of the workstream was to engage stakeholders in reviewing the existing content and co-producing a new Local Offer. This engagement involved workshops with children and young people as well as surveying parents / carers in understanding priorities for the new Local Offer. One of the key components of the new Local Offer was to ensure that content was relevant and informative. We worked with parents / carers to review content and their contribution was vital to audit the existing content and develop new information. A new online portal is also in development with specific branding and design that has been led by children and young people as well as parents / carers. This is due to launch in the summer of 2023.

1.2.10.1 Reducing health inequality

In 2019, health and care leaders across Cheshire and Merseyside outlined their collective commitment to tackling health inequalities by agreeing to become a "Marmot Community".

Following unavoidable delays due to the COVID-19 pandemic, nine Place-based workshops were held across Cheshire and Merseyside, attended by a wide-range of health, care and voluntary sector leaders.

The ground-breaking All Together Fairer[20] report for Cheshire and Merseyside, developed by Prof Sir Michael Marmot and his team, was subsequently published in May 2022 following the most comprehensive gathering of intelligence and research data on health inequalities in Cheshire and Merseyside ever completed.

In addition to intelligence about the current state of population health in Cheshire and Merseyside, All Together Fairer draws on a wider evidence base about what helps to reduce inequalities in health. This led to the development of an extensive set of evidence-based recommendations and an agenda for action on the social determinants of health that is central to the Cheshire and Merseyside Health and Care Partnership Strategy.

The 'Marmot report' also established a set of beacon indicators with which to monitor progress towards a reduction in inequalities in health in Cheshire and Merseyside.

The All Together Fairer programme deliberately and specifically focuses on social determinants of health as our health is largely shaped by the social, economic and environmental conditions in which we are born, grow, live and work in.

Shifting to a social determinants of health approach means acting on the drivers of ill-health as well as treating it. It is almost impossible to live healthily when in poverty.

It is also recognised that the NHS and Local Authorities cannot take on the required actions to reduce health inequalities alone. Partnership working with the voluntary, community, faith and social enterprise sector and other public services and businesses to influence wider conditions is required.

Capability will be developed to support delivery of the ambitions in 'Place-based All Together Fairer' programmes, linked with other local government activity and complement Cheshire and Merseyside-wide work. There is already a strong theme of working the programme through local Health and Wellbeing Boards and into wider local government strategy. The programme is a key priority within the Health and Care Partnership interim strategy with priorities identified in our Joint Forward Plan.

[20] https://www.cheshireandmerseyside.nhs.uk/media/2p5jwjs1/all-together-fairer.pdf

Case Study: Halton Primary Care Networks run screening and immunisation projects

As areas of low uptake, Runcorn and Widnes Primary Care Networks, secured funding to support local initiatives and plans to improve and address inequalities in uptake to the cancer screening programmes and / or 0-5 immunisations.

Runcorn Primary Care Network commissioned additional capacity to focus on specific cohorts of the eligible population, tailoring their approach to increase the uptake. Examples include supportive telephone conversations, support with childcare needs, and evening and weekend sessions to support those who work 9am to 5pm, Monday to Friday. The team delivered a focused campaign to target eligible cohorts of the population where uptake is low and worked with Public Health to deliver a training programme for Care Co-coordinators on how to have effective screening and immunisation conversations.

Widnes Primary Care Network developed a programme to increase the uptake of flu immunisations in school age, 2–3-year-old children, as well as eligible 18–85-year-olds. Initiatives included holding a local health forum day to promote uptake, engaging with local play centres and nurseries on the importance of flu vaccinations and working with the School Nursing team to target anyone not yet immunised as part of the school's immunisation programme. The Primary Care Network supported practices with targeted communications (text message and web-based communications) to increase uptake and with support from Public Health identified and trained practice vaccine advocates through the RSPH Level 2 Encouraging Vaccination uptake training.

Dedicated care-coordinators contacted eligible patients to make appointments and had a dedicated phoneline for patients to call for any advice and support.

Case Study: Social determinants development programme

A development programme on social determinants of health has been developed to include workshops targeted at leadership across the Integrated Care System.

Funded places at the Institute of Health Equity (IHE) summer school on social determinants of health in July, and an online platform to host material on the social determinants of health that will be maintained throughout the year.

This programme will deepen understanding of a social determinants-focused approach and help to transform practice across Cheshire and Merseyside.

Facilitation will be multi-faceted and include the Institute of Health Equity, Cheshire and Merseyside All Together Fairer Leads and Directors of Public Health and other local experts.

Benefits include:

- Accelerating progress on tackling health inequalities.
- Increased understanding of social determinants of health.
- Support system leaders to apply this understanding to their role and take full advantage of opportunities to act.
- Gain an appreciation of the issues that arise when considering social determinants of health with system leaders and recommend strategies to address.

1.2.10.2 Champs Public Health Collaborative

The Champs Public Health Collaborative[21] is a formal partnership of public health teams in Cheshire and Merseyside's nine local authorities.

Established in 2003, it is led jointly by the sub-region's Directors of Public Health. By working together on priority areas, the Collaborative pools resources, shares expertise, communicates with one voice, and enables a consistent approach across a large geography.

[21] https://champspublichealth.com/

The aim is to improve the health and wellbeing of the c2.7m people living in Cheshire and Merseyside with an ethos of collective action, local impact. Champs support our Population Health Programme Programmes of work which includes All Together Fairer (health inequalities), Health Protection, Mental Wellbeing and Suicide Prevention, Strategic Intelligence and more.

Champs also supports Integrated Care System-wide progress on prevention, inequalities, and population health through work on cross cutting enablers including strategic intelligence, communication, research and development and workforce development.

1.2.10.3 Suicide prevention programme

Cheshire and Merseyside has a strong suicide prevention programme which has a research and data intelligence strand. Since 2017 Cheshire and Merseyside has had a Real Time Surveillance (RTS) system which collates intelligence on suspected suicides, rather than waiting for the intelligence from the coronial system.

Changes to the RTS system in 2021, which is now police-led, has allowed for greater data collection, including collating intelligence about domestic abuse. From this new intelligence, it is known that between September 2021 to December 2022, 22% of suspected suicides in Merseyside were linked to Domestic Abuse (15% perpetrators and 7% victims). As a result of this intelligence, suicide prevention and domestic abuse leads are developing programmes to improve understanding of the two issues.

Further improvements in data collection will also improve understanding of the risks and where interventions will be best targeted.

Cheshire and Merseyside has also launched a new suicide prevention strategy[22] following extensive engagement, consultation and collaboration.

Local, regional and national data, evidence and intelligence have been used to collate and triangulate priority areas. Local insights were sought via workshops to support the development of the new strategy as well providing a platform to facilitate peer-led learning.

The NHS Prevention pledge

The Prevention Pledge has been adopted by seven Trusts and remaining 11 Trusts are working towards adoption, with a view to full adoption by April 2024, strengthening NHS Trust leadership for action on prevention, social value, and inequalities, and contributing to the Anchor Institute Charter, MECC, ATF, ATA, and Alcohol programmes.

Reducing harm from Alcohol

[22] https://champspublichealth.com/suicide-prevention/

During the year we have achieved the following:

- Development and expansion of the **PROACT Alcohol Care Team** workforce development offer is seen as an area of leading practice by NHSE and has enabled transformational change to be delivered though the current workforce and new roles, supporting reductions in (re)admissions and bed days.
- A **targeted awareness raising campaign**: the Lower My Drinking app campaign has continued with 1.4M impressions.
- Community **engagement in licensing** to address societal harms.
- **Collaborative commissioning** on **inpatient detoxification** is supporting increased bed placements and service provider stability.

National resources continue to fund **innovative approaches** including:

- digital delivery of IBA (Brief Advice)
- the Blue Light Project (for dependent drinkers with complex lives)
- Fibro scans for the hardest to reach with severe fibrosis or cirrhosis including a new pilot with Cobalt Housing.
- Pilots for patients with co-occurring alcohol and mental health disorders,
- targeted physical activity interventions for alcohol patients.
- Diagnostics at 32 hostels and 18 addiction services

All Together Active (ATA) strategy: As mentioned earlier we **co-developed a sub-regional physical activity strategy** with local stakeholders to support consistent sub-regional approaches to increasing physical activity while enabling local ownership by Health and Wellbeing Boards.

1.2.10.4 Fuel poverty dashboard

A significant exercise in intelligence gathering was initiated in 2022 to respond to an expected increase in the number of people living in fuel poverty in the winter of 2022-23.

Analysis was undertaken quickly, involving work with the North West Office for Health Improvement and Disparities, and included:

- Estimates of the current extent of fuel poverty across Cheshire and Merseyside and the projected worsening of the extent of fuel poverty based on estimates of rising fuel costs.
- An estimate of the unequal distribution of fuel poverty between boroughs, within boroughs and in different population groups in Cheshire and Merseyside.
- A summary of the health conditions linked to fuel poverty, distribution of such conditions across Cheshire and Merseyside and the potential impact of rising fuel poverty on health in 2022-23.

- Consideration of how rising fuel poverty and poor health would have an impact on the health and social care system in Cheshire and Merseyside.

In September 2022, the Fuel Poverty, Cold Homes and Health Inequalities Report by the Institute of Health Equity was launched. This national report had particular significance for Cheshire and Merseyside as the lead authors were from Alder Hey Children's Hospital in Liverpool.

The report drew upon research and intelligence on fuel poverty and set out four key themes to act on to reduce the impact of fuel poverty and the cost-of-living crisis in the longer term:

- Reducing deprivation and income inequality
- Improving housing quality and energy efficiency
- Addressing energy costs
- Addressing health needs and NHS interventions

The research and intelligence gathering within Cheshire and Merseyside, and the national report with significant relevance to Cheshire and Merseyside, contributed to action programmes on the fuel poverty and cost-of-living crisis within each borough and at system-level.

1.2.10.5 Digital inclusion

A Digital Inclusion Heatmap[23] Project has been undertaken to support the identification of people in Cheshire and Merseyside who are more at risk of digital exclusion and related barriers to inclusion.

The Cheshire and Merseyside digital exclusion heatmap is a valuable tool and, coupled with a research project, helped to gain a deeper understanding of specific barriers faced by the digitally excluded people across Cheshire and Merseyside so we can target the right interventions to reduce digital exclusion.

1.2.10.6 Equality, diversity and inclusion

NHS Cheshire and Merseyside has responsibility for paying 'due regard' to the Public Sector Equality Duty (PSED) - Section 149 (Equality Act 2010). Strategic Equality Diversity and Inclusion (EDI) leadership currently sits within the Central NHS Cheshire and Merseyside Director and Senior Leadership Structures. The Chief People Officer acts as the Senior Responsible Officer for EDI, Workforce and Organisational Development at Board level, while the Senior Responsible Officer for

23 https://app.powerbi.com/view?r=eyJrIjoiYzIzODYyYzAtMDQ0NC00NTA2LWEzZjEtY2NlZTE3Yzc5ZTE1IiwidCI6Ijg1OTE4ZmY4LTQ3OWYtNDZlNi1iMDE2LTE1YzY4YWVkZTc4OCJ9&pageName=ReportSection9546b630beaee0b97a00

EDI from a patient and commissioning perspective is the Assistant Chief Executive. NHS Cheshire and Merseyside has also recruited an Associate Director of EDI, who will be in post from April 2023.

To support NHS Cheshire and Merseyside to evidence how it is meeting its PSED, in February 2023 the Board approved one-year Equality Objectives (2023-24) and received both an Annual Equality, Diversity and Inclusion Annual Report (July 2022-23) and Equality Delivery Systems 2022 summary report. These documents are published on the NHS Cheshire and Merseyside website[24].

The EDI Annual report highlights a range of initiatives that have supported the organisation to promote equality of service delivery and highlights key EDI priorities moving forward.

The one-year Equality Objectives (2023-24) to support the organisation to meet its short-term priorities as its role as a leader, employer and a commissioner are to:

- Make fair, transparent, and accountable commissioning decisions.
- Improve access and outcomes for patients and communities who experience discrimination and disadvantage.
- Improve the equality performance of our providers through procurement, monitoring compliance and collaboration.
- Address inequalities (and discrimination) in the workforce so that staff are empowered and able to use their full range of skills and experience to deliver best possible services for patients and the public.

To support us with our one-year equality objectives and priorities, we will develop a system-wide EDI framework and strategy, in line with national regional and local policy. This strategy will be evidence-based and developed in partnership with the Cheshire and Merseyside health and care system.

NHS Cheshire and Merseyside facilitated the implementation of Equality Delivery Systems 2022 (EDS 2022). EDS 2022 is a mandated requirement, which comprises of three specific domains:

- Commissioned and provider services
- Workforce health and wellbeing
- Inclusive leadership.

[24] https://www.cheshireandmerseyside.nhs.uk/about/equality-diversity-and-inclusion/

Case Study: Interpreter service launched for deaf Sefton residents

In Sefton we are committed to ensuring all individuals have equitable access to services, and the team has worked with Knowsley and Liverpool to improve interpreter services for deaf patients.

Following engagement with patients highlighting the need for more responsive interpreter services, in September 2022 a new contract was awarded to Signalise Co-op to provide sign language and deafblind services to the local NHS, including GP practices, hospitals and community health services.

Following the initial success of this service, a further enhancement has been developed and is now available in local GP practices. This will allow sign language users to make calls to their GP surgery directly by phone.

Patients will do this by using the Signalise Video Relay Service (VRS) to contact a Signalise interpreter, who will then telephone their GP practice, community or hospital team and interpret the call on their behalf.

Domain One

NHS Cheshire and Merseyside developed a service review template for NHS Providers to adapt and complete for each service review. Organisations then used this document to consider information available relating to patient access, meeting health needs, patient experience and satisfaction and health outcomes. The process identified gaps in intelligence and insight which informed ratings against each outcome - and to develop individual service improvement plans. A list of data sources and publications were used for each of the Core20Plus5 clinical areas.

A series of meetings for each of the Core20Plus5 clinical areas took place between September 2022 and February 2023 with NHS provider trusts, Healthwatch and lead Place commissioning managers. Other stakeholders were also invited, such as Improving Me colleagues to the Maternity specific meetings and advocacy services to the Severe Mental Illness discussions. Contact was also made with the CHAMPS public health collaborative and cancer alliance colleagues.

NHS Cheshire and Merseyside is **Achieving** across each outcome for Domain One. This is the mode rating, as taken from the eleven NHS provider trust's individual service review ratings - who agreed to early implementation of the toolkit.

Further detail on how NHS Cheshire and Merseyside implemented Domain 1 can be viewed in the EDI Annual Report, section 5 and the EDS 2022 summary report 2022-23[25].

Performance against Domains Two and Three has been delayed due to the dependency of the assessment on the annual NHS Staff Survey results. The grading and summary report will be presented to the Board as part of a Staff Survey report in April 2023.

In addition to the work outlined above, NHS Cheshire and Merseyside has received specific papers relating to EDI, including:

- The standards and principles associated with paying 'due regard' to PSED, in the section 3 of the Assurance Process for Substantial Change report (September 2022)[26]
- EDI update (November 2022)[27]
- Liverpool University Hospitals NHS Foundation Trust Clinical Service Reconfiguration Proposal, which highlights the Board paying 'due regard' to the proposed changes, Page 7[28].

1.2.10.7 Sustainable development

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

The challenge of meeting our emissions reduction targets has undoubtedly become more difficult - COVID-19 affected every aspect of our lives and starkly exposed and exacerbated existing health inequalities within our society. Urgent work is underway to tackle the wider socio-economic and structural inequities that drive them.

We are committed to a Green Plan[29] which captures the opportunities of a transition to net zero and is aligned with the eight Marmot priorities[30]. That means progressing our work as an Anchor Institution and further embedding social value, working in partnership with our stakeholders and local populations to build greener communities, improve patient pathways, create less waste, utilise energy from

[25] https://www.cheshireandmerseyside.nhs.uk/media/qexlm5mp/nhs-cm-eds-2022-summary-report-domain-one.pdf
[26] https://www.cheshireandmerseyside.nhs.uk/media/ptdpfanz/00-icb-public-pack-v1-streamlined-compressed.pdf
[27] https://www.cheshireandmerseyside.nhs.uk/media/d33dvqjw/icb-board-meeting-agenda-papers-public-281122_compressed-v2.pdf
[28] https://www.cheshireandmerseyside.nhs.uk/media/ttplkkyj/icb-meeting-agenda-papers-271022-public.pdf
[29] https://www.cheshireandmerseyside.nhs.uk/about/green-plan/
[30] https://www.cheshireandmerseyside.nhs.uk/your-health/tackling-health-inequalities/

sustainable sources and create green jobs, develop sustainable skills and nurture good mental health and wellbeing.

This approach recognises climate change as the most significant health and human rights issue facing us today, and the purpose of this section of the report is to highlight the achievements and performance against Green Plan targets and outline how we work to support the ambitions of the wider NHS on its journey to net zero.

1.2.10.8 Tackling our carbon footprint

The journey to net zero has begun and there is a wealth of rich qualitative data by which we can document progress. In terms of quantitative analysis, NHS Cheshire and Merseyside has been engaged in ‘carbon footprinting’ work to establish an emissions baseline leading to a decarbonisation trajectory.

NHS England issued provider trust carbon footprint data (based on the Estates Returns Information Collection[31] and other sources) in November 2022. The information appears in the table and chart below.

Chart areas in green represent emissions which the NHS directly controls and shades of blue are indirect emissions arising from our procurements, non-business travel and commissioned services outside of the NHS.

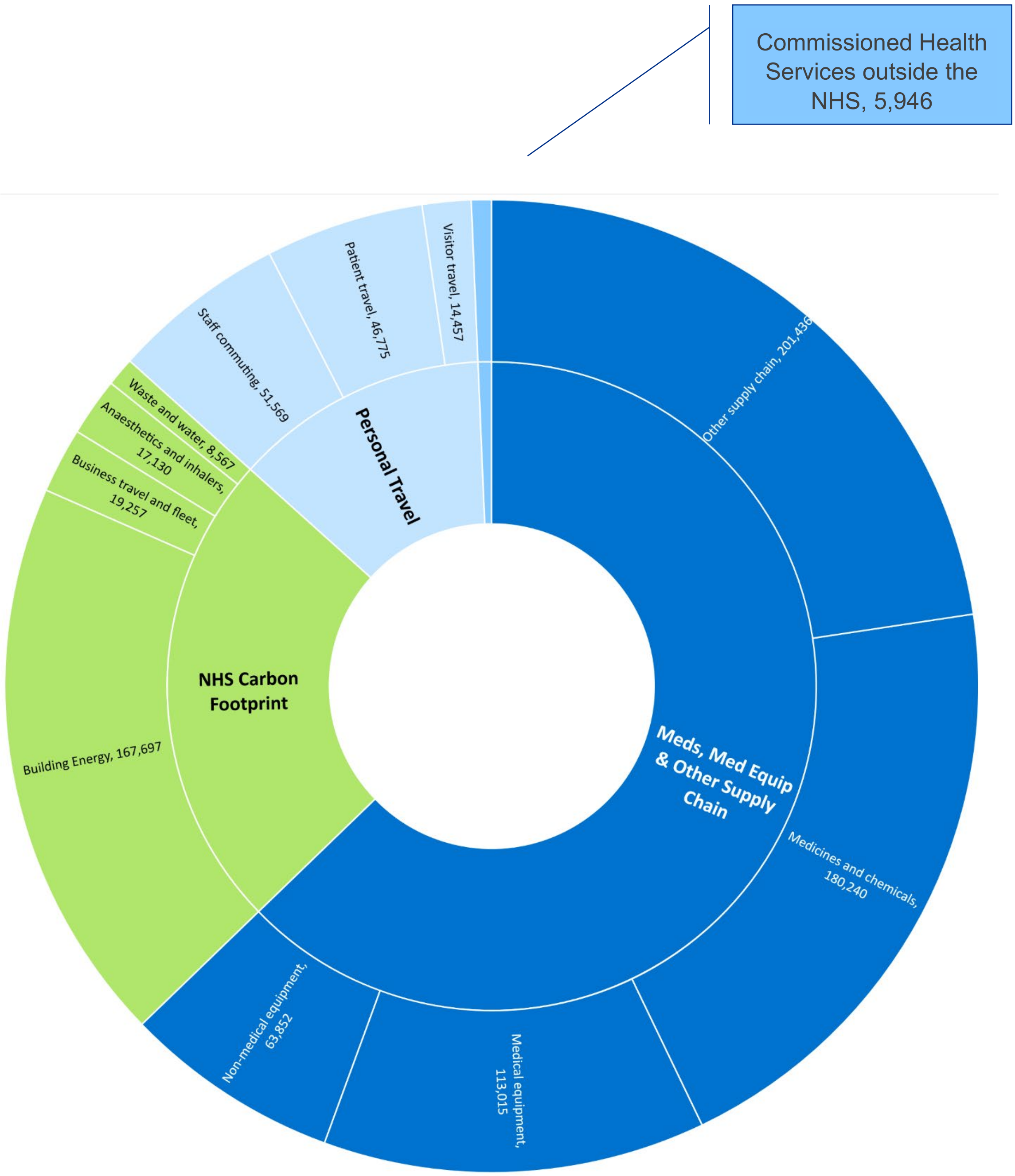
All values are expressed in tonnes of equivalent carbon dioxide emissions (tCO_2e).

Category	Sub-Category	tCO_2e
NHS Carbon Footprint	Anaesthetics and inhalers	17,130
	Building energy	167,697
	Business travel and fleet	19,257
	Waste and water	8,567
Medicines, Medical Equipment, Other Supply Chain	Medicines and chemicals	180,240
	Medical equipment	113,015
	Non-medical equipment	63,852
	Other supply chain	201,436

[31] https://www.gov.uk/government/statistics/estates-returns-information-collection-summary-page-and-dataset-for-eric-202021

Personal Travel	Patient travel	46,775
	Staff commuting	51,569
	Visitor travel	14,457
Commissioned Health Services o/s NHS	⇒	5,946

1.2.10.9 Cheshire and Merseyside provider Trust carbon footprint



<u>NHS Cheshire and Merseyside 'Carbon Footprinting'</u>

The carbon footprint of NHS Cheshire and Merseyside will be calculated in line with the Greenhouse Gas (GHG) Protocol over the course of 2023-24 following the completion of staff restructuring and estates work.

1.2.10.10 Green Plan

The Green Plan for Cheshire and Merseyside[32] was published in April 2022 and updated in July 2022 as the Integrated Care Boards came into operation. The Plan reflects the ambitions of NHS Cheshire and Merseyside, aligned with the Marmot priorities and the sustainable ambitions of our provider trusts.

<u>Adaptation</u>

Climate adaptation and mitigation is a key priority for NHS Cheshire and Merseyside and involves adapting to the current and future effects of climate change; reducing mortality and morbidity associated with climate change, ensuring resilience and service continuity, and actions or processes that strengthen capacity to provide quality care while the climate changes.

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

Five of Cheshire and Merseyside's provider trusts have been piloting NHS England's new climate change risk assessment tool since October 2022. Monthly support sessions are in place to report progress and feedback on the CCRA to NHS England. Results will determine priority areas of action across our system; we expect these to be coastal flooding, mitigation against sustained high temperatures and heatwaves and air quality.

<u>Biodiversity</u>

Biodiversity projects have been implemented across the system and Nature Recovery Rangers are in place at Liverpool University Hospitals NHS Foundation Trust. Tree planting projects to mark the Queen's Platinum Jubilee Celebrations (the

[32] https://www.cheshireandmerseyside.nhs.uk/about/green-plan/

Queen's Green Canopy) were effected throughout 2022 and an additional 150 trees were donated to the Cheshire and Merseyside system. The Sustainability Team put the donor in contact with Mersey Forest to identify where best to plant and to advise on which native species should be planted.

Digital Transformation

Our Digital and Data Strategy aligns with the sustainability agenda in facilitating delivery of alternative models of care with a lower carbon footprint. Examples include reducing avoidable face-to-face appointments by providing increased access to virtual consultations, health monitoring and virtual wards. Digital inclusion work supports social value aims and will help to reduce health inequalities. Projects delivered in 2021-22 included distribution of refurbished NHS laptops to people and communities identified as being at risk of digital exclusion.

Estates and Facilities

Energy and decarbonisation of the NHS estate is an area of concern. Rising energy prices have meant that the 578 GWh of energy used by trusts is set to rise from a cost of £41m to c£110m at current rates. Decarbonisation is also costly. Whereas LED lighting schemes generally pay for themselves within two years and generate savings thereafter, other projects require significant capital expenditure / investment.

The Integrated Care System convened an Energy Sub-Group of its Sustainability Board in January 2023 following a unanimous decision by the provider trusts and NHS Cheshire and Merseyside to tackle energy together. Plans are in place to draw on collective system expertise, to promote learning and innovation, and to support colleagues across the system with Public Sector Decarbonisation Scheme and other funding bids. We will also continue to liaise with local authority colleagues around connectivity to alternative sources of renewable energy.

HR and Organisational Development

A system-wide Net Zero Leadership workshop for Executive and Non-Executive Directors was held in February 2023. From April 2023 all staff will be required to complete a "Becoming a Net Zero NHS" module as part of their statutory and mandatory training.

Medicines, Prescribing and Anaesthetic Gases

During 2022-23 work to decrease emissions arising from medicines, prescribing and anaesthetic gases increased exponentially across the Cheshire and Merseyside in both primary and secondary care.

Significant decreases have been made by provider trusts in the use of the most potent anaesthetic gases, including desflurane and nitrous oxide in particular. The use of desflurane (an anaesthetic gas with a global warming potential 2,500 times that of carbon dioxide) has been eliminated in the majority of our trusts and its overall usage is ≤4% of all anaesthetic gases used in Cheshire and Merseyside.

Case Study: Impact of Prescribing for asthma and COPD – Liverpool

More than half of Liverpool patients with asthma and two-thirds of people with COPD are prescribed eight or more short acting beta agonists (SABA) a year, representing poor management of conditions and high environmental impact.

Central and North Liverpool PCN conducted pilots in 2021-22 to address these issues and achieved some success in inhaler switching and in developing resources and training to support this. The pilots however, also highlighted significant difficulties in achieving the reductions required to meet NHS net zero targets. These difficulties included staff capacity, gaps in system leadership, management and data provision, low nurse engagement and lack of patient engagement and stretch on review time to cover environmental aspects. The pilots generated significant learning to increase effectiveness and a revised approach has been planned to tackle poor asthma control and environmental impacts of inhaler prescribing.

To bring this plan to life, Liverpool applied and was successfully awarded a Healthy Futures Action Fund from Greener NHS to take forward a project during 2022-23 working across Liverpool Place, PCNs, GPs, pharmacists, nurses and secondary care specialists and engaging asthma patients to develop the work from the pilot to create the culture change necessary to reduce emissions and improve care and patient outcomes. This will report in early 2024.

Travel and Transport

As part of calculating its carbon footprint, NHS Cheshire and Merseyside will launch a staff wide travel and transport survey in the second half of 2023. Achievements over 2022-23 have included:

- System-wide deal with Arriva buses for NHS staff to offer discounted rates on monthly bus travel passes.
- Cycle to work scheme offered across NHS Cheshire and Merseyside.
- Ultra-low and zero emission vehicles (ULEVs and ZEVs) included in staff car lease scheme.

Collaboration with Liverpool John Moores University and Liverpool University Hospitals NHS Foundation Trust on air quality monitoring pilot. Data from the pilot will be triangulated with respiratory data and other research to form part of a campaign to promote active travel and better public transport infrastructure.

1.2.10.11 Delivering social value

While recycling, investing in renewable energy and switching to LED lighting, and other planet friendly initiatives are hugely important and vital in our journey to net zero, we know that – alone – they are insufficient to achieve the scale of decarbonisation required in the NHS. In Cheshire and Merseyside we are designing care around our patients, with a community based, person centred, approach which is focused on wellness, from a system that understands more about its people in their Places and communities and the challenges which they face.

Anchor Institution

Working as an anchor institution involves using the size and influence of NHS Cheshire and Merseyside to leverage wider health, financial, societal, and environmental benefits.

For example, procuring and employing locally and working in ‘anchor networks’ to tackle environmental factors which contribute to poor health such as air pollution.

The Cheshire and Merseyside Anchor Charter[33] was launched in July 2022. The Charter framework was developed over an 18-month period with colleagues and local communities, building on the Social Value Charter and Cheshire and Merseyside’s Social Value Award[34] work. It has a series of principles and priorities which organisations can sign up to commit to deliver on.

We have engaged in further work with our communities to determine the measurement tool to ensure the right outcomes are delivered through the anchor framework. Each organisation that has signed the Anchor Charter and committed to delivering on the anchor framework will have their progress evaluated using the measurement tool through our newly formed Anchor Assembly.

The Anchor Assembly will meet bi-annually in July and January and comprise representation from the Chair of NHS Cheshire and Merseyside, stakeholders from local authorities, the third sector and citizens. The Assembly will both provide assurance and offer opportunities for collaboration and anchor networking.

[33] https://www.cheshireandmerseyside.nhs.uk/media/ka3da1gn/anchor-institute-charter-and-principles.pdf
[34] https://www.socialvaluebusiness.com/social-value-award

Social Value

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

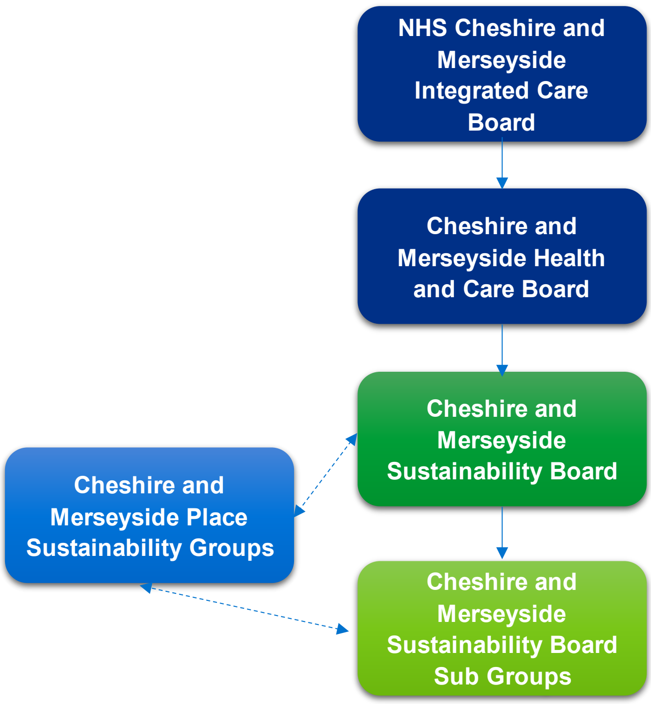
In conjunction with the Social Value Portal NHS Cheshire and Merseyside has implemented a system-wide social value framework[35] to collectively and consistently measure the social value that we are delivering through a collective set of system themes, outcomes, and measures (TOMs). NHS Cheshire and Merseyside is the first Integrated Care Board in the country to embark upon this as an entire system and to do so with partners who include local authorities, provider trusts, and the VCFSE sector.

This is a joined-up approach to social value while also enabling bespoke delivery within each organisation. The TOMs align with the Social Value Charter, Anchor Framework, Green Plan and the eight Marmot priorities.

The collective TOMs will be formally signed-off in April 2023 and data collation and reporting will then commence.

1.2.10.12 Governance

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



[35] https://www.cheshireandmerseyside.nhs.uk/media/dftnomvj/social-value-charter.pdf

1.2.11 Financial Performance July 2022 - March 2023

1.2.11.1 Statutory Duties

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

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

NHS Cheshire and Merseyside has achieved its financial duties for the period 1 July 2022 to 31 March 2023.

1.2.11.2 Financial Performance

NHS Cheshire and Merseyside has delivered a surplus (underspend) of £12.746m against its spending allocation for the period 1 July 2022 to 31 March 2023.

NHS Cheshire and Merseyside was established by transferring the assets and liabilities of nine pre-existing CCGs on 1 July 2022. In addition to the transfer of the assets and liabilities, NHS Cheshire and Merseyside inherited an historical overspend and after consideration NHS England and NHS Improvement have agreed that the balance inherited deficit of £185.12m will be written off on the condition that NHS Cheshire and Merseyside achieves its agreed financial plan for the two years following its establishment.

Separate to this, historical agreements guaranteeing CCG drawdown have been transferred into NHS Cheshire and Merseyside as historic allocations which equated to a further allocation of £7.960m. However, access to this funding in year was subject to national affordability and approval and as such NHS Cheshire and Merseyside was unable to access this funding in year.

Therefore, NHS Cheshire and Merseyside retains a cumulative surplus of £20.436m against its spending allocation as at 31 March subject to the achievement of the financial plan in 2023-24.

The following table summarises NHS Cheshire and Merseyside’s spending in the nine months to 31 March 2023:

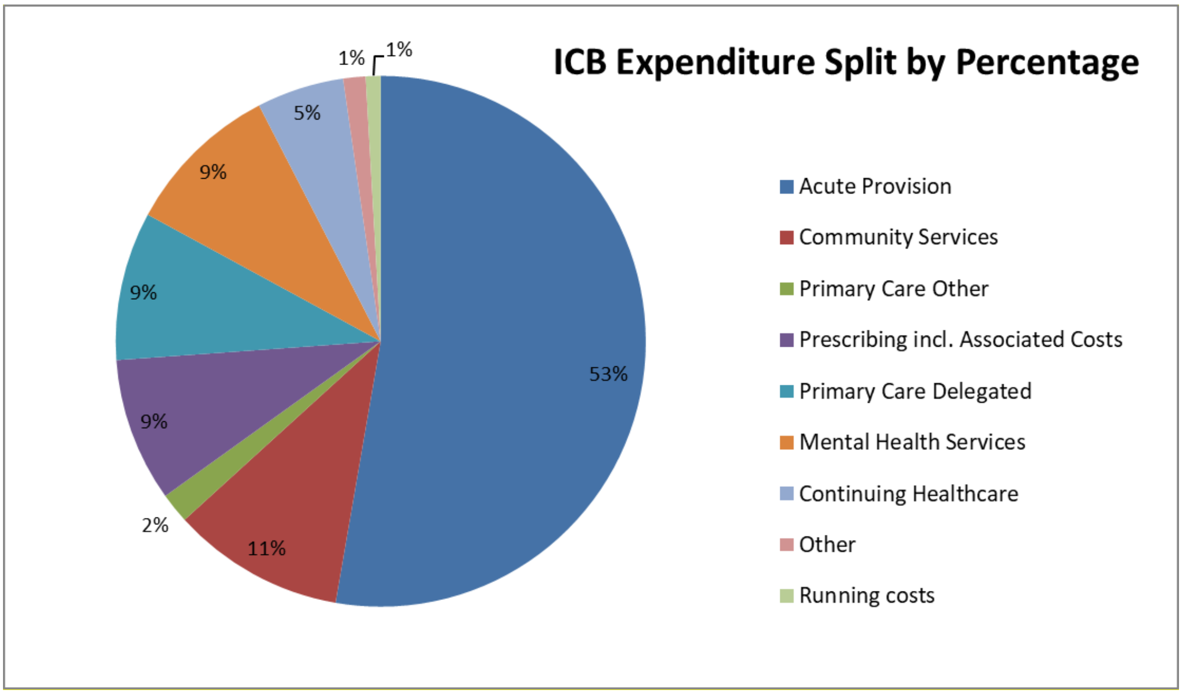
Area of Expenditure	Q2-4 2022-23		
	In Year Allocation £000s	Expenditure £000s	Surplus/ (Deficit) £000s
Programme	4,540,794	4,528,918	11,876
Running Costs	42,220	41,350	870
Total	**4,583,014**	**4,570,268**	**12,746**

1.2.11.3 Financial Analysis

The analysis below provides further information regarding NHS Cheshire and Merseyside expenditure for the nine months of 2022-23 financial year.

Expenditure Area	2022-23 (M4-12) £000s
Acute Provision	2,408,847
Community Services	481,298
Primary Care Other	82,740
Prescribing incl. Associated Costs	402,115
Primary Care Delegated	413,536
Mental Health Services	433,894
Continuing Healthcare	243,112
Other	63,376
Total Programme Expenditure	**4,528,918**
Running costs	41,350
Total	**4,570,268**

The chart below shows the relative percentage of NHS Cheshire and Merseyside expenditure against the reporting categories:



1.2.11.4 Provider Information

The table below provides information on NHS Cheshire and Merseyside's programme expenditure with the top 15 NHS providers for nine months to 31 March 2023. These providers account for £2.836b or 63% of overall NHS Cheshire and Merseyside Programme expenditure.

Provider	**£000s**
Liverpool University Hospital NHS Foundation Trust	562,113
Merseycare NHS Foundation Trust	330,213
St Helens and Knowsley NHS Foundation Trust	320,562
Wirral University Teaching Hospital NHS Foundation Trust	284,549
Mid Cheshire NHS Foundation Trust	232,958
Warrington NHS Foundation Trust	209,578
Countess of Chester Hospital NHS Foundation Trust	190,092
Cheshire and Wirral Partnership NHS Foundation Trust	132,297
Southport and Ormskirk Hospital NHS Trust	124,296
East Cheshire NHS Foundation Trust	113,534
North West Ambulance Service NHS Trust	98,000
Liverpool Women’s NHS Foundation Trust	77,920
Alder Hey Children’s NHS Foundation Trust	73,714
Wirral Community Health and Care NHS Foundation Trust	44,749
Bridgewater Community Healthcare NHS Foundation Trust	41,451
Total Programme Spend Top 15 NHS providers	**2,836,026**
Other programme spend	1,692,832
Total programme spend	**4,528,858**
Running costs	41,410
Total spend	**4,570,268**

1.2.11.5 Mental Health

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

	2022-23 **£000s**
Mental Health Spend	495,578
NHS Cheshire and Merseyside Programme Allocations	4,540,794
Mental Health Spend as a proportion of NHS Cheshire and Merseyside Programme Allocation	11%

Graham Urwin

Graham Urwin

Accountable Officer

29 June 2023

2. Accountability Report

2.1 Accountability Report

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

It comprises three sections:

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

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

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

2.2 Corporate Governance Report

2.2.1 Members Report

2.2.1.1 Chair and Chief Executive

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

2.2.1.2 Board

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

The membership of the Board during 2022-23 is set out below:

Name	Position	From	To
Raj Jain	Chair	1 July 2022	Present
Tony Foy	Non-Executive Director	1 July 2022	Present
Erica Morriss	Non-Executive Director	1 July 2022	Present
Neil Large MBE	Non-Executive Director	1 July 2022	Present
Hilary Garrett CBE	Non-Executive Director	18 January 2023	Present
Dr Naomi Rankin	Partner Member	1 January 2023	Present
Adam Irvine	Partner Member	1 July 2022	Present
Professor Stephen Broomhead MBE	Partner Member	1 July 2022	Present
Cllr Paul Cummins	Partner Member	1 July 2022	Present
Ann Marr OBE	Partner Member	1 July 2022	Present
Joe Rafferty CBE	Partner Member	1 July 2022	Present
Graham Urwin	Chief Executive	1 July 2022	Present

Name	Position	From	To
Claire Wilson	Executive Director of Finance	1 July 2022	Present
Professor Rowan Pritchard-Jones	Medical Director	1 July 2022	Present
Marie Boles	Interim Executive Director of Nursing and Care	1 July 2022	31 July 2022
Christine Douglas MBE	Executive Director of Nursing and Care	1 August 2022	Present

2.2.1.3 Directors

NHS Cheshire and Merseyside's directors, in addition to those on the Board listed above, during 2022-23 are set out below:

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

Place Directors			
Name	**Position**	**From**	**To**
Mark Wilkinson	Place Director – Cheshire East	1 July 2022	Present
Delyth Curtis	Place Director – Cheshire West	1 July 2022	Present

Place Directors			
Name	**Position**	**From**	**To**
Anthony Leo	Place Director – Halton	1 July 2022	Present
Alison Lee	Place Director – Knowsley	1 July 2022	Present
Jan Ledward	Place Director – Liverpool	1 July 2022	Present
Deborah Butcher	Place Director – Sefton	1 July 2022	Present
Mark Palethorpe	Place Director – St Helens	1 July 2022	Present
Carl Marsh	Place Director – Warrington	1 July 2022	Present
Simon Banks	Place Director – Wirral	1 July 2022	Present

Further information regarding NHS Cheshire and Merseyside's Board members and directors can be found on our website[36].

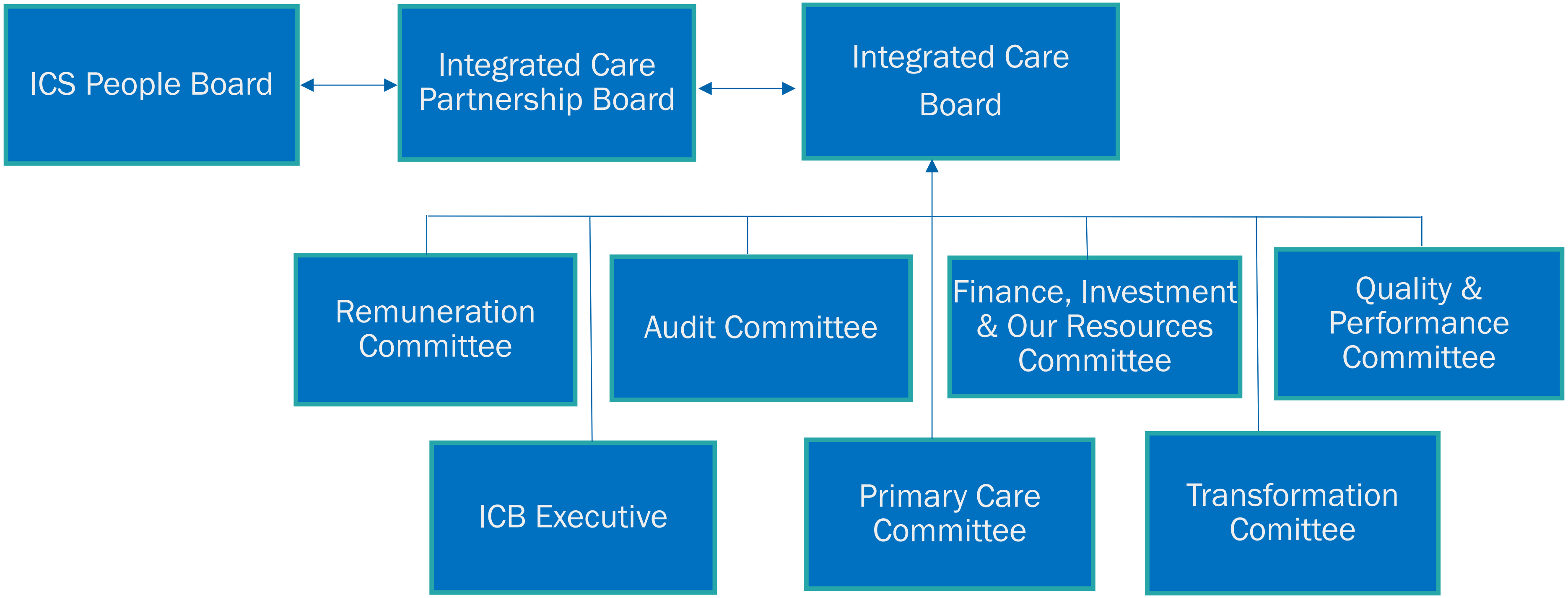
2.2.1.4 Committee(s), including Audit Committee

The members of the Audit Committee during the period covered by this report are set out in appendix 1 on page 152.

NHS Cheshire and Merseyside's governance and committee structure is set out in the diagram overleaf. The membership of, and attendance at each committee is provided in appendix 1.

[36] https://www.cheshireandmerseyside.nhs.uk/about/nhs-cheshire-and-merseyside/leadership-team/

2.2.1.5 Integrated Care Board Governance and Committee Structure



2.2.1.6 Register of Interests

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

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

These registers can be found on our website[37].

Between 1 July 2022 and 31 March 2023 there were no reported breaches of the Conflicts of Interest policy and procedures.

NHS Cheshire and Merseyside has in place a Conflicts of Interest Policy which sets out the approach to managing conflicts of interest (including gifts, hospitality and sponsorship). This was ratified by the Board on 1 July 2022; and was updated in October 2022 to reflect an update in the agreed approach to evidencing training compliance. A copy of the policy can be found on our website[38].

2.2.1.7 Personal data related incidents

NHS Cheshire and Merseyside's arrangement for information governance are described in the Governance Statement on page 92.

There were no personal data related incidents during the year which required formal reporting to the Information Commissioner's Office.

2.2.1.8 Modern Slavery Act

NHS Cheshire and Merseyside fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2023 is published on our website[39].

2.2.2 Statement of Accountable Officer's Responsibilities

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

[37] https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/managing-conflicts-of-interest/
[38] https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/managing-conflicts-of-interest/
[39] https://www.cheshireandmerseyside.nhs.uk/about/equality-diversity-and-inclusion/modern-slavery-act-statement/

state of affairs of NHS Cheshire and Merseyside and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

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

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

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

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

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

2.2.2.1 Governance Statement

2.2.2.2 Introduction and context

NHS Cheshire and Merseyside is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

NHS Cheshire and Merseyside's statutory functions are set out under the National Health Service Act 2006 (as amended).

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

Between 1 July 2022 and 31 March 2023, NHS Cheshire and Merseyside was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

2.2.2.3 Scope of responsibility

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

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

2.2.2.4 Governance arrangements and effectiveness

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

The Integrated Care Board constitution[40] commits NHS Cheshire and Merseyside to, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England. NHS Cheshire and Merseyside has agreed standards of business conduct.

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

These set out the expected behaviours that members of the Board and its committees will uphold while undertaking NHS Cheshire and Merseyside business, and principles that will guide decision making.

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

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

NHS Cheshire and Merseyside has published a functions and decision map[41], which provides a high-level structural chart setting out which decisions are delegated and taken by which parts of the system.

NHS Cheshire and Merseyside has also published a scheme of reservation and delegation[42], which sets out those decisions which are reserved to the Board and those which have been delegated.

NHS Cheshire and Merseyside's Governance Structure Chart is in the Members Report on page 86. Details of the membership and attendance at the Board and each of its committees is provided in appendix 1 on page 151. The key responsibilities of the Board and each of its committees, highlights of their work, and assessment of their performance and effectiveness over the year is provided below.

2.2.2.5 NHS Cheshire and Merseyside Board

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

a) Improve outcomes in population health and healthcare.
b) Tackle inequalities in outcomes, experience and access.
c) Enhance productivity and value for money.
d) Help the NHS support broader social and economic development.

The Board remains accountable for all of the Integrated Care Board functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation. Each NHS Cheshire and Merseyside Committee provides an update and assurance to the Board on the areas contained with each respective committee terms of reference.

During 2022-23 effective from 1 July 2022, the Board has met eight times and was quorate on each occasion. Key activities of the Board included:

[41] https://www.cheshireandmerseyside.nhs.uk/media/caxfszcj/functions-and-decisions-map.pdf
[42] https://www.cheshireandmerseyside.nhs.uk/media/lxdfkwlk/cm-sord.pdf

- Approval of members of the Board, including Non-Executive and Executive Directors and Partner members.
- Approval of the Chair for the Integrated Care Partnership.
- Approval of the NHS Cheshire and Merseyside Constitution and Standards of Business Conduct.
- Approval of NHS Cheshire and Merseyside Public Engagement and Empowerment Framework.
- Approval of NHS Cheshire and Merseyside Policy for Public Involvement.
- Approval of NHS Cheshire and Merseyside Scheme of Reservation and Delegation (SORD), Functions and Decisions Map, Standing Financial Instructions (SFI) and Operational Limits.
- Approval of NHS Cheshire and Merseyside core governance structure and terms of reference for all committees.
- Noted key roles for specific individuals for the Senior Information Risk Officer (SIRO) and Caldicott Guardian.
- Received update and assurance reports from all committees with delegated authority.
- Noted performance and financial reports.
- Approved the clinical case for the establishment of a North Mersey comprehensive stroke service for hyper acute services for North Mersey and West Lancashire.
- Approved proposals for the Liverpool University Hospitals NHS Foundation (LUHFT) clinical services reconfiguration.
- Noted presentations from Places in the context of the demographics and geography.
- Noted updated reports from the Executive Director of Nursing and Care.
- Noted report on winter planning for 2022-23.
- Endorsed NHS Cheshire and Merseyside Integrated Care System Digital and Data Strategy.
- Approval of retirement of the Continuous Glucose Monitoring Policy with a progress update in 12 months' time.
- Noted an update on the Provider Collaborative.
- Approved the Cheshire and Merseyside Health and Care Partnership Interim Draft Strategy 2023-24.
- Approved the NHS Cheshire and Merseyside Equality, Diversity and Inclusion Annual Report 2022-23.
- Approved the NHS Cheshire and Merseyside Risk Management Strategy.
- Noted an update on NHS England Primary Care delegation to NHS Cheshire and Merseyside.
- Approved the Joint Working Agreement with Northwest Specialised Commissioning.

- Noted an update on Cheshire and Merseyside Cancer Alliance.

2.2.2.6 Audit Committee

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

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

During 2022-23 effective from 1 July 2022, the Audit Committee has met three times and was quorate on each occasion. Key activities of the Committee included:

- Reviewed committee terms of reference and the principal role of the committee.
- Received updates on the arrangements for management of conflicts of interest and risk management.
- Received an update on the process and progress for the production of the Annual Report and Accounts for 2022-23.
- Received an update on recommendations regarding legacy issues from Clinical Commissioning Groups (CCGs) from Mersey Internal Audit Agency (MIAA).
- Received an update on internal and external audit contract arrangements, including a draft internal audit workplan for 2022-23.
- Recommended the approval of the NHS Cheshire and Merseyside Anti-Bribery and Counter Fraud Policy and Information Governance Policy, statements, and privacy notices.
- Update on the results of a self-assessment undertaken against the Healthcare Financial Management Association (HFMA) and update on actions to address issues identified.
- Update reports on approvals of NHS Cheshire and Merseyside procurement tender waivers and the intention to publish the procurement decision register on the NHS Cheshire and Merseyside website.
- Approval of award of External Audit Service contract.
- Update on arrangements and proposed developments for whistleblowing and the Freedom to Speak Up (FTSU) Guardian
- Recommendation to the Board on proposed changes to the Operational Scheme of Reservation and Delegation (SORD)
- Review of bi-monthly Information Governance reports.
- Update report on losses and special payments.
- Reviewed a report outlining management responses made to External Audit to inform the assessment on a number of key areas.

- Received a progress report from Internal Audit in relation to the 2022-23 Internal Audit Plan.
- Received an indicative draft Internal Audit Plan for 2023-24.
- Received an Anti-Fraud Progress Update report.
- Received two reports relating to a recent bank mandate fraud with updates on the investigation progress.
- Received a verbal update on progress for the Data Security and Protection Toolkit (DSPT) submission.

2.2.2.7 Remuneration Committee

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

During 2022-23 effective from 1 July 2022, the Remuneration Committee has met five times and was quorate on each occasion. Key activities of the Committee included:

- Reviewed committee terms of reference and the principal role of the committee.
- Considered a verbal update on the intent to develop a set of principles for Partner Member remuneration.
- Agreed the salaries of all directors (including those holding joint appointments with Local Authorities) within the above ranges and confirmed that they would not consider any salary in excess of the nationally recommended pay ranges.
- Consideration of the approach to reducing NHS Cheshire and Merseyside's running costs.
- Update on the national pay award to very senior managers (VSM) with an agreement to adopt the recommendation in the guidance.
- Approval of terms and conditions for clinical roles (GP) of NHS Cheshire and Merseyside including Associate Medical Director, Senior Clinical Lead, Clinical Lead and Named GP for Safeguarding.
- Consideration of the terms and conditions for NHS Cheshire and Merseyside's Medical Director.
- Approval of a remuneration rate for those NHS Cheshire and Merseyside Partner Members entitled to payment.

2.2.2.8 Integrated Care Board Executive

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

In addition, the NHS Cheshire and Merseyside Executive will provide direction, as a Category 1 responder and that NHS Cheshire and Merseyside supports its Partners with system and borough-wide planning and activity. It will also make decisions in respect of system Quality Innovation Productivity and Prevention (QIPP) and financial recovery, any such decision shall be reported to the next meeting of the Board for ratification.

During 2022-23 effective from 1 July 2022, the Executive Team (including Place Directors) has met 34 times. Key activities from the meeting included:

- Approval of the Care and Education Reviews.
- Endorsed the submission of Clinical and Care Professional Leadership Framework.
- Received assurance and update on the final Readiness to Operate Statement (ROS) submission, which was also endorsed.
- Endorsed the Virtual Wards approach for 2023-24.
- Endorsed the following target operating models in advance of the board meeting: Primary Care, Communications and Engagement and Corporate Affairs and Governance.
- Endorsed the recommendations within NHS Cheshire and Merseyside's Transformation and Change Support Outcome Report. For which the Chief Executive reported back to Board.
- Agreed the recommendations set out in the NHSE paper 'Roadmap for integrating Specialised Services within Integrated Care Systems.
- Noted and agreed the Specialist Educational Needs and Disabilities (SEND) recommendations prior to being taken to the Board.
- Endorsed the Digital Target Operating Model.
- Endorsed the roll out of a new IT tenant for NHS Cheshire and Merseyside staff.
- Endorsed the Section 140, Mental Health Act protocol prior to it going to the Board.
- Noted and endorsed the adult social care transformation plan.
- Noted and endorsed the future model and functions of Area Prescribing Committees (APC) within Cheshire and Merseyside.
- Endorsed the Accelerated Access Collaborative (InHIP Programme) and Cheshire and Merseyside recommendations.

- Endorsed the Sustainability and Social Value, portal, training and funding recommendations.
- Noted and endorsed the recommendations for Covid Medicines Delivery Units (CMDU) – Transition of response to business as usual.
- Agreed APC changes to prescribing recommendations set out by NICE, in the absence of a formal committee to do this.
- Noted and endorsed the NHS Cheshire and Merseyside Digital and Data Strategy.
- Endorsed the pre-delegation assessment framework: specialised services for submission.
- Endorsed the immediate roll out of the Prometheus Programme within Cheshire and Merseyside.
- Agreed to progress with preferred salary sacrifice/lease car scheme.
- Noted and agreed the roll out of the Expansion of Employment Advisors in Improving Access to Psychological Therapies (IAPT) across Cheshire and Merseyside.
- Noted and supported the recommendations of an All Age Continuing Healthcare Review.
- Supported the recommendations for the System Strategic Co-ordination Centre.
- Supported and approved the set-up of Cheshire and Merseyside ADASS Programme Office.
- Endorsed the primary care rebate scheme for Cheshire and Merseyside.
- Noted and endorsed the recommendations for clinical policy harmonisation.
- Agreed to sign Cheshire and Merseyside up to the Care Leaver Covenant.
- Noted and endorsed the recommendations set out for the management of Refugee and asylum seekers being received into Cheshire and Merseyside.
- Approved business critical roles to be advertised and recruited to.

2.2.2.9 Finance, Investment and Our Resources Committee (FIRC)

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

During 2022-23 effective from 1 July 2022, the FIRC has met five times and was quorate on each occasion. Key activities of the Committee included:

- Reviewed committee terms of reference and the principal role of the committee.
- Reviewed and agreed an annual committee workplan.
- Noted the ongoing financial positions in respect of both revenue and capital allocations.

- Approval of 14 digital programme investments in respect of national funding streams.
- Received an update on Liverpool University Hospitals NHS Foundation Trust (LUHFT) finance review.
- Received an update on the development of the Integrated Care System Financial Strategy and operational financial policies.
- Received an update on the workforce consultation process and organisational change process, noting progress on organisational structures.
- Noted recommended updates to NHS Cheshire and Merseyside's Operational Scheme of Reservation and Delegation (SORD) and work required on the authorised signatory list.
- Noted the 2023-24 NHS Planning Guidance and associated requirements and submission deadlines.
- Received an update on the planning position in relation to finance, activity, performance, and workforce.
- Noted the level of risk in delivering the forecast outturn position.

2.2.2.10 Quality and Performance Committee

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

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

During 2022-23 effective from 1 July 2022, the Quality and Performance Committee has met eight times and was quorate on each occasion, with the exception of the inaugural meeting held in August 2022.

Key activities of the Committee included:

- Reviewed committee terms of reference and the principal role of the committee.
- Reviewed and agreed an annual committee workplan.
- Noted the work to date on the development of a quality and performance dashboard.
- Reviewed GP Patient Survey results for 2022.

- Received assurance reports from the Cheshire and Merseyside Antimicrobial Prescribing Board.
- Received an update on arrangements for medicines optimisation and safety.
- Received an update on the Care Quality Commission.
- Escalation to the Board of issues relating to Annual Health Checks for people with learning disabilities.
- Escalation of the ‘No One is Listening Enquiry’ to the Board which considered serious failings into the care of patients with sickle cell. Assurance was provided that a consistent approach is now in place with haematology leads across Cheshire and Merseyside.
- Received a presentation from the Cancer Alliance.
- Discussion regarding performance in UEC and cancer waiting times.
- Aggregated key issue reports from the Associate Directors of Quality and Safety Improvement from all nine Places.
- Update and assurance reports from the Cheshire and Merseyside All Age Continuing Healthcare System Oversight Group.
- Consideration of the One-to-One Midwifery investigation and ongoing updates on the implementation of actions to address the recommendations.
- Assurance reports relating to the National Screening and Immunisation Programme.
- Endorsement of the Managing Allegations Made Against Staff in Respect of Children, Young People and Adults at Risk Policy, the Domestic Abuse Support for Employees Policy and the Mental Capacity Act (2005) Policy.
- Update from the System Quality Board, including themes of pressures within NWAS and the residential sector for care of the older people.
- Update on analysis of patient experience themes and trends.
- Review of the quality and performance dashboard and management of risks.
- Update on a Rapid Quality Review planned for Cheshire and Wirral Partnership NHS Foundation Trust.
- Update on the findings of a review of maternity services at East Kent Hospital including discussion about whether assurance was being received that similar events were not occurring locally.
- Update on the Local Maternity and Neonatal System report and how this has evolved in line with the development of the Integrated Care System.
- Overview of the approach to Equality Duty Service (EDS) reviews during 2022-23.
- Update on the Cheshire and Merseyside Digital Transformation programme with a request for a future focus on impact on quality and safety as a result of the programme.
- Overview of Mental Health Transformation and challenges in place.

- Updates on the quality and performance related risks on the risk register including an overview of work undertaken to date.
- Update on the work undertaken regarding clinical policy harmonisation and the quality impact assessment (QIA) process.
- Update from the LeDeR (people with a learning disability and autistic people) Team regarding the national programme and changes relating to the establishment of Integrated Care Boards.
- Received a report on Patient Safety and the state of readiness for transition to the national Patient Safety Incident Response Framework (PSIRF).
- Approved terms of reference for the Clinical Effectiveness Group.
- Received a report on infection, prevention and control governance and performance for NHS Cheshire and Merseyside and the Integrated Care System.
- Update report from NWAS in relation to patient safety because of system pressures.

2.2.2.11 System Primary Care Committee

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

During 2022-23 effective from 1 July 2022, the System Primary Care Committee has met six times and was quorate on each occasion. Key activities of the Committee included:

- Reviewed committee terms of reference and the principal role of the committee.
- Received an update on the Primary Care Operating Model and on national and local Primary Care Contracting.
- Received updates on the financial position relating to primary care finance.
- Agreed a Dispute Resolution Process for Primary Care Contracts (General Medical/Primary Medical and Alternative Provider of Primary Medical Services contracts).
- Received minutes and decisions of the Pharmaceutical Services Regulations Committee, which were endorsed.
- Updates from Warrington Place in relation to the Enhanced Access Consultation.
- Updates from Places relating to Primary Medical Services (PMS) Contracts and financial positions.
- Updates on the transfer process from NHS England of Dental and General Ophthalmic Services (GOS).
- Agreement to various issues escalated by Place to the Committee, including Alternative Provider Medical Services (APMS) Contracts (West Cheshire and

Liverpool) and list closure extension (West Cheshire), APMS extension request (St Helens), practice merger (Sefton), and Primary Care IT funding (all Places).

- Updates from Place Directors in relation to access to general practice and transformation and development.
- Updates on key changes to the Community Pharmacy Contract and challenges and opportunities.
- Agreement to support the matrix of decision making to enable Place Based decision making in respect of the Policy and Guidance Manual.
- Update on escalated security issues in general practice in Liverpool.
- Update on actions related to primary care workforce.
- Received a general Community Pharmacy update, including an Expression of Interest for Independent Prescribing in Community Pharmacy Pathfinder Programme.
- Update on the primary care risk register.
- Received Place updates on newly awarded primary care spend, including the impact on patients and outcomes and an update on current pressures in general practice.
- Approval of the Locally Commissioned Community Pharmacy Schemes and Minor Ailment Schemes.

2.2.2.12 Transformation Committee

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

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

During 2022-23 effective from 1 July 2022, the Transformation Committee has met three times and was quorate on each occasion. Key activities of the Committee included:

- Reviewed committee terms of reference and the principal role of the committee.
- Considered the draft Integrated Care System Digital and Data Strategy.
- Updates on the programme and approach to the current change activity occurring across Places, Corporate Programmes and Provider Collaboratives.
- Update on the NHS England Substantial Service Change Assurance process with an agreed action to develop a prioritisation process for substantial change.

- Noted the process for the development of the Cheshire and Merseyside Health and Care Partnership Strategy and associated deadlines.
- Received a Transformation Programme Assurance Report outlining the refreshed governance arrangements for programme activity.
- Received an update on Treating Tobacco Dependency (TTD).
- Noted a paper from Champs regarding the need to do a rapid scoping review regarding the future of smoking cessation.
- Update on transformation programmes and future planning, including the alignment of the planning guidance and programme mapping as well as funding considerations for 2023-24.
- Received a presentation which outlined the plan for year one of the 3-year plan for the VCFSE transformation programme.
- Received a report on the implementation of the teledermatology service and current financial pressures to the programme.
- Updates on specialised commissioning, major change, NHS England primary care transfers for delegated functions and digital transformation and clinical improvement.

2.2.2.13 Cheshire and Merseyside Health and Care Partnership

Cheshire and Merseyside Health and Care Partnership is the sub-region's statutory Integrated Care Partnership. It includes membership from the NHS, local authorities, voluntary sector, housing, police and the fire and rescue service.

The Partnership provides a multi-agency forum to assess the health, public health and social care needs of people across Cheshire and Merseyside. A combined strategy will be developed to address these needs.

Draft Terms of Reference are being reviewed by the nine local authorities and NHS Cheshire and Merseyside with a view to agreeing a collective set by May 2023.

During 2022-23 effective from 1 July 2022, the Health and Care Partnership has met three times and was quorate on each occasion. Key activities of the Health and Care Partnership included:

- Review of draft Terms of Reference, with acknowledgement of the need for formal engagement with the nine Local Authority representatives. Terms of Reference would also require approval by each Place council meeting.
- Appointment of Chair and Vice Chairs
- Received a presentation on the Marmot Programme from public health.
- Received a presentation on fuel poverty and the health impact.
- Update on the interim Cheshire and Merseyside Health and Care Partnership Strategy.
- Noted the content of the national 2023-24 NHS planning guidance and the need to develop NHS Cheshire and Merseyside Joint Forward Plans to reflect priorities.

- Received a presentation from Skills for Care (strategic workforce development and planning body for adult social care in England) on the challenges and opportunities relating to recruitment and retention of adult social care workforce.
- Held a workshop to consider the Cheshire and Merseyside Health and Care Partnership priorities.

2.2.2.14 UK Corporate Governance Code

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

2.2.2.15 Discharge of Statutory Functions

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

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

2.2.2.16 Risk management arrangements and effectiveness

NHS Cheshire and Merseyside's Risk Management Strategy sets out its statement of intent, organisational arrangements, systems and processes for risk management and assurance. It was developed based on best practice and subject to consultation within NHS Cheshire and Merseyside and with its internal auditors.

Risks arise from a range of external and internal factors, and the identification of risks is the responsibility of all NHS Cheshire and Merseyside staff. This is done proactively, via regular planning and management activities and reactively, in response to inspections, alerts, incidents and complaints.

All risks are assessed to determine:

- A clear description identifying the cause, effect and impact on NHS Cheshire and Merseyside
- Ownership of the risk including operational and executive leadership and overseeing committee
- Strategic objective or function that will be impacted by the risk
- Controls that are currently in place to mitigate the risk and an assessment of their effectiveness
- An evaluation of the impact and likelihood of the risk using NHS Cheshire and Merseyside's risk matrix to arrive at an inherent and current risk rating
- Risk proximity indicating whether the impact will be immediate, within or beyond the current year

- Appropriate risk treatment and further mitigation action based on risk tolerance and cost effectiveness
- Sources of assurance in respect of key control measures

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

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

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

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

NHS Cheshire and Merseyside has no tolerance for safety risks that could result in avoidable harm to patients.

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

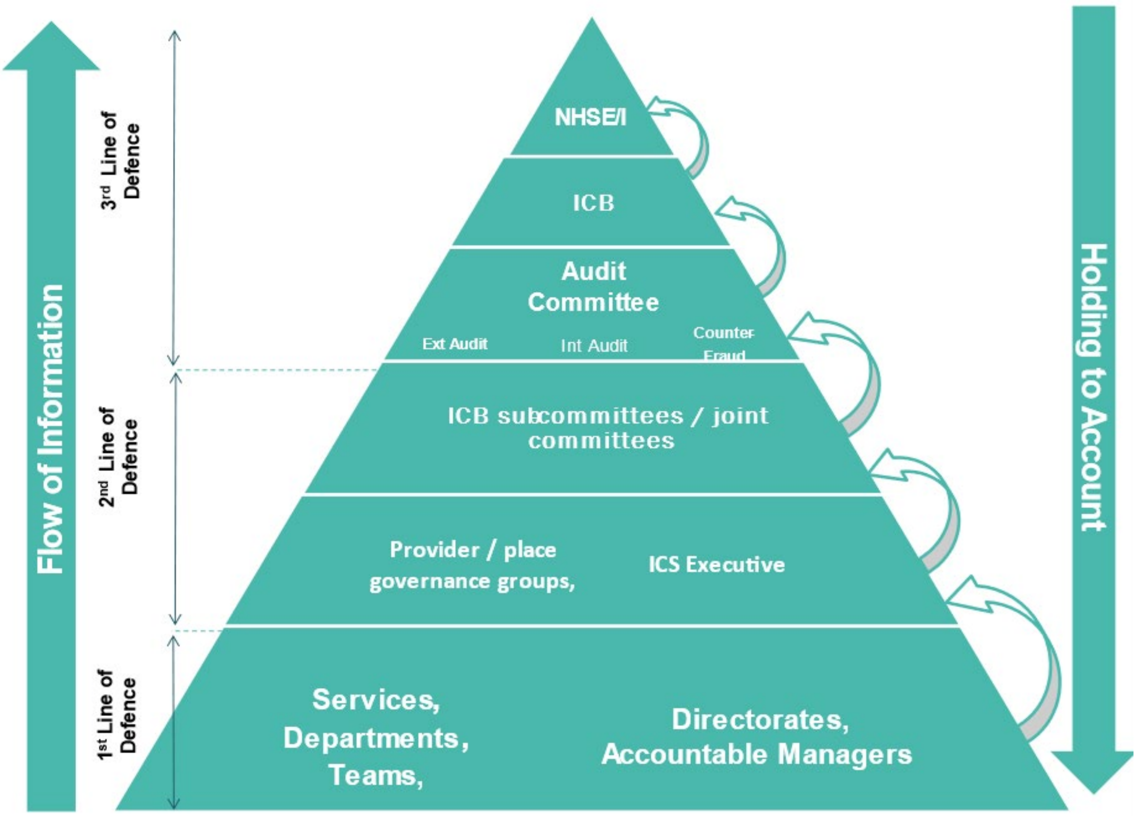
We will pursue innovation to achieve our transformational objectives and are willing to accept higher levels of risk which may lead to significant demonstrable benefits to our patients and stakeholders, while maintaining financial sustainability and efficient use of resources. We will support local system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

NHS Cheshire and Merseyside has developed a comprehensive strategy and robust processes for risk management. Implementation is ongoing and work is underway to complete and embed these across the organisation.

2.2.2.17 Capacity to Handle Risk

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

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



This includes:

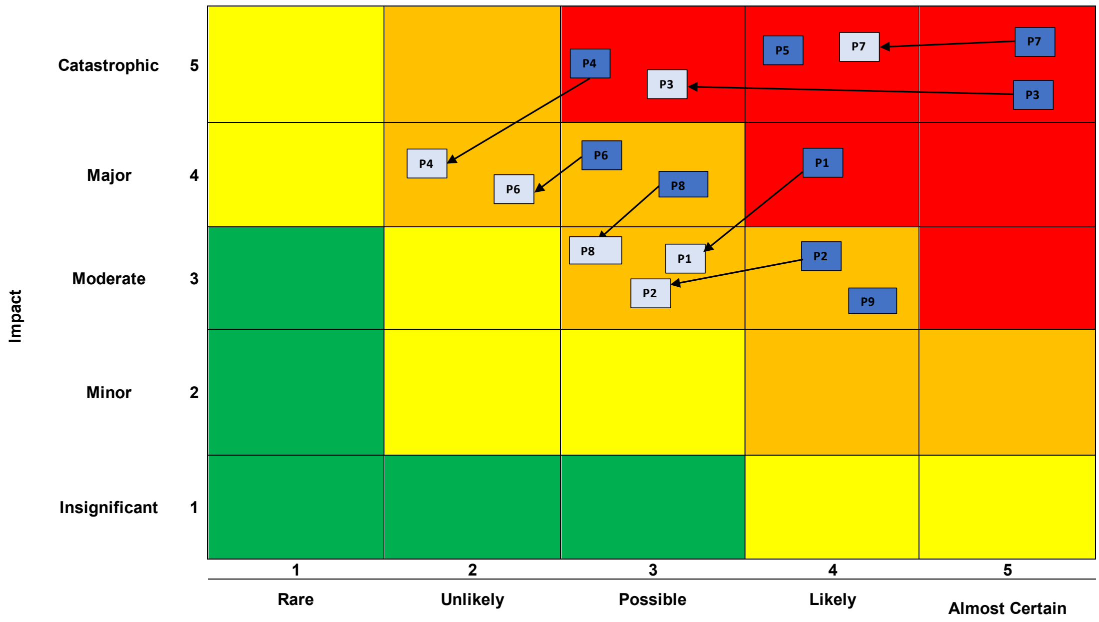
- 1st line - Senior Responsible and Operational Leads have ownership, responsibility and accountability for directly assessing, controlling and mitigating risks.
- 2nd line - strategic leadership and oversight through the Board, its committees, place boards and reporting groups, leadership teams, and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

The pace of implementation has been dictated by the establishment of organisational structures, operating models, strategies and plans. The initial focus has been on identifying the most significant risks in relation to quality, performance and finance. The Board Assurance Framework will be presented to the Board at its April meeting 2023 and risk reports are in place for the majority of committees and expected to be complete in May 2023.

The Risk Management Strategy, templates and guidance has been presented To corporate and place teams, governance leads and risk practitioners, to support initial implementation. A more extensive and comprehensive training and development programme will be created and rolled out over the next six months.

2.2.2.18 Risk Assessment

NHS Cheshire and Merseyside's Board Assurance Framework identifies 10 principal risks to the delivery of NHS Cheshire and Merseyside's strategic objectives, as summarised in section 1.1.3 on page 113 of the performance report. The level and spread of NHS Cheshire and Merseyside's strategic risks is indicated below.



Risks to governance, risk management and internal control are summarised below.

There are controls in place, including policies, processes, communications, training, information security systems and effective contracts and contract management in relation to commissioning support services. Work is ongoing to further develop and embed these as the organisational structure and operating model evolve and mature. Assurance will be provided through regular scrutiny and reporting at the Audit Committee.

Risk	Risk Rating
Non-compliance with information governance policies leads to reportable data security and protection incident resulting in financial loss and / or reputational damage	**Moderate (6)**
Commissioning support or other data processors acting on NHS Cheshire and Merseyside's behalf breach statutory or regulatory requirements resulting in financial loss and / or reputational damage	**High (9)**
Business continuity incident impairs NHS Cheshire and Merseyside's ability to deliver statutory duties and functions resulting in reputational damage and / or financial loss	**High (8)**
Lack of capacity and / or clarity on roles and authority during period of establishment of NHS Cheshire and Merseyside's structure leads to delayed delivery of business priorities resulting in reputational damage and ineffective/inefficient working	**High (9)**
Inconsistent adherence to core set of governance, financial and operational policies and procedures across NHS Cheshire and Merseyside leads to control failures, poor audit outcomes and reputational damage	**High (9)**
Internal controls are insufficient to prevent fraudulent activity by NHS Cheshire and Merseyside staff, contractors, patients or other third parties resulting in financial loss and / or reputational damage	**TBC**
Incident arising from unsafe working practices or environment leads to death or injury for which NHS Cheshire and Merseyside is liable resulting in financial loss and / or reputational damage	**Moderate (6)**

2.2.2.19 Internal Control Framework

A system of internal control is the set of processes and procedures in place in NHS Cheshire and Merseyside to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

NHS Cheshire and Merseyside's internal control framework comprises:

- The Board Assurance Framework, which is framed around NHS Cheshire and Merseyside's strategic objectives. This is being developed and will be reviewed and managed by NHS Cheshire and Merseyside's Executive Committee, reported quarterly to the Board and scrutinised by the Audit Committee.
- An internal audit service commissioned from Mersey Internal Audit Agency (MIAA) and delivering a comprehensive and balanced audit plan which is approved and monitored by the Audit Committee. This provides an objective challenge and valuable insight into risks, control weaknesses and opportunities for improvement
- Anti-fraud arrangements described in paragraph 2.2.2.28
- The governance framework described in paragraph 2.2.2.4
- The NHS Cheshire and Merseyside Executive Team and Non-Executive Directors
- The application of agreed policies and procedures, principally the corporate governance handbook including schemes of reservation and delegation and standing financial instructions.

This internal control framework is informed and assured by external scrutiny and review, including the NHS England System Oversight Framework and External Audit.

2.2.2.20 Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest (published June 2016) requires commissioners to undertake an annual internal audit of conflicts of interest management. To support Integrated Care Boards to undertake this task, NHS England has published a template audit framework.

An internal audit of conflicts of interest has been completed by MIAA and found that since the establishment of the ICB that the control framework has significantly progressed its development and implementation of core controls.

A Local Proactive Exercise was also undertaken by the MIAA Anti-Fraud Specialist with regards Declarations of Interest completeness, with the aim to assess whether declaration returns submitted to-date within the ICB are fully complete, or whether only partial or inaccurate returns have been made. Undeclared conflicts of interest has been a fraud risk identified at several NHS organisations in recent years. Testing was completed and identified no instances of fraud; however, recommendations were made to address a small number of low-risk issues identified during the Exercise, all of which have now been addressed.

2.2.2.21 Data Quality

The importance of data quality is well recognised by NHS Cheshire and Merseyside and is critical in the production of accurate analysis which underpins and influences commissioning decisions, priorities, contractual performance and assurance activities. NHS Cheshire and Merseyside has identified and specified the data requirements for both effective monitoring of the performance, quality and safety of commissioned services and to support its plans to redesign and re-commission services. These form the basis of regular reporting to NHS Cheshire and Merseyside, and its committees.

Data quality standards and requirements from commissioned providers are set out in data and quality contract schedules. The service agreements with NHS Cheshire and Merseyside's commissioning support providers include requirements for data validation and quality control.

NHS Cheshire and Merseyside has worked in partnership with its commissioning support providers to further develop the quality and design of reports and other business intelligence products. Performance data has been supplemented by intelligence from patient feedback, quality monitoring visits, audits, and contract monitoring activity to provide a broader view of performance than solely quantitative metrics.

The NHS Cheshire and Merseyside Business Intelligence team produces a routine data quality briefing report. This reviews the key contractual and performance data sets required to be submitted by providers either to meet national data requirements e.g., Secondary Users Services (SUS), Community Services Data Set (CSDS) or any local data requirements to support contracts e.g. SLAM. The monthly report includes the timeliness of data submissions, data quality, data validity e.g., a recent focus on the ethnicity coding to enable analysis to support targeted action to reduce health inequalities. The report provides benchmarking of the national datasets against peers in addition to a regular overview of the Data Quality Maturity Index which provides an overview of data quality in the NHS by provider across the numerous data sets submitted. Actions to pick up on the findings from the report are led by the Business Intelligence team, working with providers through the respective information sub groups, which form part of the contractual governance structure.

2.2.2.22 Information Governance

NHS Cheshire and Merseyside has a robust information governance framework, which includes:

- The roles of Senior Information Responsible Officer (SIRO), Caldicott Guardian, and the Information Governance Lead, who advise and support NHS Cheshire and Merseyside's Executive Team in relation to information governance matters

- An information governance handbook and code of conduct, data protection and security policy, supported by briefings and training for all Board members and staff
- An information asset register, and data flows map which record the nature and security arrangements for the data held and transmitted, including sensitive and confidential data, and the risks and security arrangements, which are regularly assessed and reviewed
- Access to specialist expertise and advice, including scrutiny, challenge and spot checks, through commissioning support arrangements
- Bi-monthly reports on compliance which are reported to the Audit Committee and an annual review by internal audit.

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to NHS Cheshire and Merseyside, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing / have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

2.2.2.23 Business Critical Models

The data and intelligence provided through NHS Cheshire and Merseyside's commissioning support provider to inform needs analysis and service commissioning is subject to robust quality assurance both internally by the provider and by NHS Cheshire and Merseyside. NHS Cheshire and Merseyside's plans and forecasts are also subject to external scrutiny and sign-off by NHS England.

2.2.2.24 Third party assurances

NHS Cheshire and Merseyside relies on a number of third-party service provider organisations such as Capita (for primary care support / payments), NHS Shared Business Services Limited (for the provision of general ledger finance and accounting services - including invoice payment), St Helens and Knowsley Hospitals (for payroll services), NHS Midlands and Lancashire Commissioning Support Unit (for Human Resources Support).

Typically, each area except for the Capita primary care support services and NHS Shared Business Services Limited, which are the responsibility of NHS England and Improvement, has a lead officer who maintains a client relationship with the service provider.

Those relations extend to regular contact and meetings with the providers, participation in client satisfaction ratings and where required intervention where performance falls below a satisfactory level. As appropriate, external standards and service delivery levels are monitored and by exception any assurance failings brought to the immediate attention of NHS Cheshire and Merseyside.

Assurance on these services is gained by independent service audits on the controls operated by these service providers which is commissioned directly by the contract holder, in most cases NHS England. NHS Cheshire and Merseyside reviews the independent audit reports for control issues at those service providers to assess whether there are adequate compensating controls to mitigate any risks to the ICB that might arise. After reviewing compensating controls operated by the NHS Cheshire and Merseyside, the issues identified in reports relating to the period to 31 March 2023 do not present a significant risk that would impact on the ICB directly.

2.2.2.25 Control Issues

As explained in Head of Internal Audit Opinion (see section 2.2.2.29 below), there was no assurance framework in place in 2022-23. As a new organisation formed from nine pre-existing CCGs, assurance was sought on the risks and issues that might have transferred to NHS Cheshire and Merseyside. The controls operated in the period mirrored the controls operated by those pre-existing bodies. Because there were no significant changes in the operations from that of the predecessor organisations in the period, and the Board operated committees worked closely with management in relation to risks arising in operational areas as explained in section 2.2.2.17, these compensating processes mitigated against further risks that might affect the ability to meet its statutory duties.

2.2.2.26 Review of economy, efficiency and effectiveness of the use of resources

Under its constitution, NHS Cheshire and Merseyside is required to ensure it receives value for money. To ensure that resources are used economically, efficiently and with effectiveness:

- The Board provides active leadership of the organisation within a framework of prudent and effective controls that enable risk to be assessed and managed.
- The Governance, Audit Committee, as a committee of the Board, is pivotal in advising the Board on the effectiveness of the system of internal control and use of resources. Any significant issues would be reported to the Board via the Audit Committee.
- NHS Cheshire and Merseyside's committees' responsibilities include overseeing the development and review of: strategy and commissioning plans, annual commissioning intentions, financial plans (including delivery), undertaking detailed scrutiny of performance, contract monitoring and financial management on behalf of NHS Cheshire and Merseyside, and also review and monitor the organisational improvement plan. NHS Cheshire and Merseyside's committees formally report to the Board, escalating issues as required.
- Directors' roles and responsibilities are aligned to ensure systems of internal control are in place and implemented effectively throughout the organisation.
- The constitution includes a Scheme of Reservation and delegation which sets out the procurement processes and financial limits that are delegated to management.
- A procurement strategy and procurement processes have been developed in the year that includes securing both quality services and value for money as key criteria.
- As explained throughout this report, extensive partnership working with local councils and with service providers in undertaken through our place structure which helps ensure that local services are designed and delivered with economy, efficiency and effectiveness as a key priority.
- Processes are monitored through risk assessment and through regular reports on procurement, including any tender waivers together with the reasons for those waivers.
- Internal Audit provides reports to each meeting of the Audit Committee and full reports to the Executive Director of Finance. The Audit Committee also receives details of any actions that remain outstanding from the follow up of previous audit work. The Executive Director of Finance also meets regularly with the Audit Manager.
- External Audit provides external audit annual management letter and progress reports to the Audit Committee. External audit will provide a report on the arrangements to deliver value for money.

The NHS Oversight assurance framework is aligned to the ambitions set out in the NHS Long Term Plan and in operational planning and contracting guidance issues for 2022-23. Metrics in relation to Finance and Use of resources include Financial Efficiency, Financial Stability, Achievement of the Mental Health Investment Standard and Agency Spending. These are also areas of focus for the Board.

For 2021-22 CCGs were assessed via the national NHSE assurance process, the assessment for which was based on a single set of metrics of five ‘national themes’ that reflect the ambitions of the NHS Long Term Plan (applied across trusts, commissioners and Integrated Care Systems). The five themes include quality of care; access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources and leadership and capability.

2.2.2.27 Delegation of functions

NHS Cheshire and Merseyside has delegated responsibility for some of its functions to committees and this is set out in terms of reference and the scheme of reservation and delegation. The Board remains accountable for these functions and has put in place reporting and assurance arrangements requiring all committees to:

- Submit regular reports of their business to NHS Cheshire and Merseyside
- Make minutes of their meetings available to NHS Cheshire and Merseyside
- Prepare an annual report outlining how it has delivered its responsibilities and submit this to NHS Cheshire and Merseyside

The ICB has also entered into individual Section 75 arrangements with each of the nine Local Authorities across Cheshire and Merseyside. Through these individual arrangements the ICB has delegated decision making authority to each Place through the formation of Section 75 Joint Committees with the Local Authorities, and authority given to ICB representatives on budgets and functions that fall under the individual Section 75 Agreement, for example in relation to the Better Care Fund.

The ICB has also discharged significant decision-making authority to a number of key posts within the ICB which enables these individuals to have the authority to make decisions on behalf of the ICB on functions and budgets within a number of forums across all nine Places in Cheshire and Merseyside. This authority is outlined within the ICB Scheme of Reservation and Delegation and Standing Financial Instructions.

2.2.2.28 Counter fraud arrangements

NHS Cheshire and Merseyside’s Anti-Fraud, Bribery and Corruption Policy and Response Plan sets out its commitment to reducing the level of fraud, corruption and bribery within the NHS to an absolute minimum, as well as the arrangements that are in place to deter, prevent, detect and investigate any such instances carried out against NHS Cheshire and Merseyside.

NHS Cheshire and Merseyside's anti-fraud, bribery and corruption service is provided by Mersey Internal Audit Agency (MIAA). Through MIAA, NHS Cheshire and Merseyside has a suitably qualified, nominated Anti-Fraud Specialist to support compliance with the Government Functional Standard 013 for Counter Fraud (NHS Requirements).

The Executive Lead responsible for fraud, bribery and corruption is the Executive Director of Finance. The Associate Director of Finance - Planning and Reporting is NHS Cheshire and Merseyside's nominated Counter Fraud Champion.

NHS Cheshire and Merseyside demonstrates compliance with the NHS Requirements through activities including:

- An annual anti-fraud work plan for NHS Cheshire and Merseyside is agreed by the Audit Committee, with consideration to local and national fraud risks and intelligence and prioritising required action, including local proactive exercises in areas determined to be high fraud risk.
- NHS Cheshire and Merseyside participates in national proactive exercises including the National Fraud Initiative and takes appropriate action in respect of any recommendations made by the NHS Counter Fraud Authority.
- NHS Cheshire and Merseyside's Anti-Fraud Specialist produces and presents the Audit Committee with regular progress reports throughout the year, detailing progress against the anti-fraud work plan and interim assessment against the NHS Requirements.
- NHS Cheshire and Merseyside's Anti-Fraud Specialist produces an Annual Report for presentation to Audit Committee, detailing work undertaken across the year and an assessment against the NHS Requirements.

2.2.2.29 Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 July 2022 to 31 March 2023 for NHS Cheshire and Merseyside, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of NHS Cheshire and Merseyside's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

The overall opinion for the period 1 July 2022 to 31 March 2023 provides **Limited Assurance: there is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls impacts on the overall system of internal control and puts the achievement of the organisation's objectives at risk.** The opinion is not limited in scope but is provided in the context of the maturity of the organisation during the time of reporting.

Integrated Care Boards were established on 1 July 2022 and this financial year is one of transition. Taking this fact into consideration, we have undertaken ongoing risk assessments throughout this 9-month period and have focussed our work on core and mandated areas and included wider assurance on key areas utilising core controls assurance mechanisms.

The complexity of the ICB, in terms of bringing together nine CCGs, as well as other organisations to form the ICB (and continuing to inhouse teams during first year of operation), together with its maturity have been significant factors in determining the Head of Internal Audit Opinion. It is fully acknowledged that positive assurances have been provided a number of the financial core systems and that progress continues regarding the development and embedding of the control framework. However, this opinion covers the period from establishment until the 31 March 2023 and for the majority of the core areas reviewed by internal audit, the outcomes have highlighted that whilst the development and embedding of the control framework has continued to progress, this hasn't been fully operational for the period under review.

This opinion is provided in the context of NHS Cheshire and Merseyside's size, demographics, in year establishment and organisational maturity.

The basis for forming our opinion is as follows:

Basis for the Opinion
1. An assessment of the design and operation of the underpinning Assurance Framework, risk management systems and supporting processes.
2. An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of systems reviewed and management's progress in respect of addressing control weaknesses identified.
3. An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented.

Commentary

The commentary below provides the context for our opinion and together with the opinion should be read in its entirety.

Our opinion covers the period 1 July 2022 to 31 March 2023 inclusive and is underpinned by the work conducted through the risk based internal audit plan.

2.2.2.30 Assurance Framework

Opinion

Structure	No opinion able to be provided as the organisation has not had an AF in place during 2022-23
Risk Appetite	
Engagement	
Quality and Alignment	

2.2.2.31 Core and Risk-Based Reviews Issued

We issued:

Risk Management Core Controls*	The control framework has significantly progressed its development and implementation of core controls.
Governance Core Controls	The control framework has continued to progress, both in design and implementation
Conflicts of Interest Core Controls*	The control framework has significantly progressed its development and implementation of core controls.
Quality Governance Core Controls*	The control framework has significantly progressed its development and implementation of core controls.
Information Governance Core Controls (Draft)*	NHS Cheshire and Merseyside is progressing with the development and implementation of core controls.
HfMA Improving NHS Financial Sustainability Checklist*	Self-assessment was not fully complete at time of initial submission Self-assessment was appropriately approved Self-assessments against the 12 NHSE specified questions reviewed by internal audit were deemed to be reasonable
Financial Governance*	The control framework has significantly progressed its development and implementation of core controls.
Key Financial Systems* • General Ledger • Accounts Receivable • Accounts Payable	 Substantial Assurance Substantial Assurance Moderate Assurance
Data Security and Protection Toolkit*	N/A – Feedback provided to support the submission to NHSD in line with their timescales (30 June 2023)

Mandatory Training	Assurance that effective processes have been established for the completion and monitoring of mandatory training.
Pre-Delegation Assessments for Direct Commissioning Support	Assurance that effective processes have been established for the completion and monitoring of transition plans

- Identified priority areas for in-year delivery to the Head of Internal Audit Opinion for 2022-23

2.2.2.32 Follow Up

During the course of the year we have undertaken follow up reviews and can conclude that the organisation has made good progress with regards to the implementation of recommendations. We will continue to track and follow up outstanding actions.

Chris Harrop

Managing Director, MIAA

March 2023

Louise Cobain

Assurance Director, MIAA

March 2023

2.2.2.33 Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within NHS Cheshire and Merseyside who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance and risk management framework provides me with evidence that the effectiveness of controls that manage risks to NHS Cheshire and Merseyside achieving its principles objectives have been and continue to be reviewed.

I have been advised on the implications of the result of this review by:

- The Board
- The Audit Committee
- The Quality and Performance Committee
- The Executive Team Committee
- Internal audit

The role and conclusions of each have been considered in the Corporate Governance Report above.

During the year the Board and Audit Committee have kept under regular review the application of the system of internal control. With the support of Internal Audit where areas for improvement have been identified, prompt appropriate actions have been taken to address any gaps in control and changes made to ensure that the systems in place remain robust and effective.

During the first year of establishment of the ICB developed its Board Assurance Framework and its Corporate Risk Register as further enhancements to strengthen the organisations approach and management of risk.

2.2.2.34 Conclusion

Whilst in receipt of a Limited Assurance Opinion from our Internal Auditors and some risks have been identified in the main body of the Governance Statement above, none present a significant control issue.

2.3 Remuneration and Staff Report

Introduction

The remuneration and staff report sets out NHS Cheshire and Merseyside's remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers and where relevant the link between performance and remuneration.

The Government Financial Reporting Manual requires NHS bodies to prepare a Remuneration Report containing information about directors' remuneration. In the NHS, the report will be in respect of the Senior Managers of the NHS body. 'Senior Managers' are defined as: 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of NHS Cheshire and Merseyside as a whole, rather than the decisions of individual directorates or departments.' For the purposes of this report, this includes NHS Cheshire and Merseyside's Board.

2.3.1 Remuneration Report

2.3.1.1 Remuneration Committee

This report:

- sets out the process under which the Chair, Executive Directors, and Non-Executive Directors were remunerated for the financial period 1 July 2022 to 31 March 2023
- sets out tables of information showing details of the salary and pension interests of all directors for the financial period 1 July 2022 to 31 March 2023.

The Remuneration Committee is established by NHS Cheshire and Merseyside as a Committee of the Board in accordance with its Constitution. The Remuneration Committee is responsible for determining the remuneration and terms and conditions of the Chief Executive, executive directors and non-voting directors. The Committee is chaired by a Non-Executive Director and membership comprises all other non-executive directors. Committee meetings are considered to be quorate when a minimum of two Non-Executive Directors are present. Attendance at meetings during this year are shown at Appendix 1 on page 152.

The Chair undertakes the annual appraisal of the non-executive directors and the Chief Executive, who in turn is responsible for assessing the performance of the executive directors.

The Committee convened four times during the year and its work has included following matters of business:

- Approval of the Remuneration Committee Terms of Reference
- Approval of the VSM Pay Framework
- Approval of salaries for the following roles:
    - Executive Director of Finance
    - Executive Medical Director
    - Executive Director of Nursing and Care
    - Chief People Officer
    - Chief Digital Officer
    - Director of Planning and Performance
    - Assistant Chief Executive
    - Place Directors x 9
    - Managing Director at CMAST
    - Deputy Medical Director
    - Associate Medical Directors
    - Deputy Director of Finance
    - Deputy Director of Nursing and Care
- In line with NHS Cheshire and Merseyside's Management of Change Policy, approved salary protection for two years from July 2022 in respect of four former Accountable Officers of CCGs who were displaced as a result of the disestablishment of CCGs and the creation of NHS Cheshire and Merseyside.
- Approved the remuneration of Partner members who are entitled to receive a payment.
- Approved the payment of a 3% pay award for staff on VSM contracts.
- Approved progressing the application to NHS England to run an Integrated Care Board MARS scheme.

The Chief Executive, the Chief People Officer and the Associate Director of Governance and Corporate Affairs (Company Secretary) are normally in attendance at meetings of the Committee, to provide advice and expertise except when their positions are being discussed and the Committee has the option to seek further professional advice as required.

In circumstances where one or more senior managers are paid more than £170,000, NHS Cheshire and Merseyside is required to explain the steps taken to satisfy itself that this remuneration is reasonable and seek approval from HM Treasury to pay such a salary. In respect of those very senior managers in NHS Cheshire and Merseyside who are paid more than £170,000, NHS Cheshire and Merseyside has considered comparable data from other similar organisation in determining the rate that should be paid to attract and retain staff with the requisite skills and experience to deliver in these challenging roles. The Remuneration Committee has committed to work within the national pay framework.

The work of the Committee is subject to an independent level of scrutiny.

In compliance with Article 21 of the General Data Protection Regulation (GDPR) each member of the Board, detailed in the tables below, have given their consent for their information to be included.

2.3.1.2 Fair Pay Disclosure (subject to audit)

Percentage change in remuneration of highest paid director

As the percentage change in remuneration of the highest paid director is a comparison to the previous financial year, NHS Cheshire and Merseyside is unable to calculate the increases in average staff pay for staff as a whole by comparison with the highest paid director (based on that director's midpoint banding) as a result of 2022-23 being the first operational year as an entity.

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	N/a	N/a
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	N/a	N/a

Pay ratio information

In the financial period 2022-23 the banded remuneration of the highest paid director was £257,500.

The relationship to the annual remuneration of the organisation's workforce is disclosed in the below table.

2022-23	25th percentile	Median pay ratio	75th percentile pay ratio
Total annual remuneration (£)	£34,943	£46,040	£58,748
Salary component of total annual remuneration (£)	£34,943	£46,040	£58,748
Pay ratio information	**7.37 : 1**	**5.59 : 1**	**4.38 : 1**

During the reporting period 2022-23, no employee received remuneration in excess of the highest-paid director/member. Annual remuneration on a full-time equivalent basis ranged from £21,932 to £257,500.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Because this is the first period of operation for NHS Cheshire and Merseyside, there are no comparative figures.

2.3.1.3 Policy on the remuneration of senior managers

In determining and reviewing remuneration for Executive Directors, NHS Cheshire and Merseyside's Remuneration Committee takes into account relevant benchmarking with other NHS organisations, guidance from NHS England, national inflationary uplifts recommended for other NHS staff and any variation or change to the responsibilities of Directors and the financial circumstances relating to NHS Cheshire and Merseyside. For the purposes of the Annual Report Senior Managers are defined as those in Board level positions. Senior managers at NHS Cheshire and Merseyside do not receive performance-related pay or bonuses. All Executive Directors / Other Board Directors have employment contracts which are usually awarded on a permanent basis, unless the post is for a fixed period of time. Executive Directors (including the Chief Executive) have a 6-month notice period within their contracts of employment.

2.3.1.4 Remuneration of Very Senior Managers

In respect of those senior managers who are paid more than £170,000 per annum, NHS Cheshire and Merseyside, via it's Remuneration Committee takes steps to ensure such remuneration is reasonable and commensurate with the individual's experience, by way of reference to the VSM Pay Framework and guidance issued to Integrated Care Boards and considering benchmarking data from other similar organisations.

2.3.1.5 Senior manager remuneration (including salary and pension entitlements) (Subject to audit)

Name	Title	1 July 2022 to 31 March 2023					
		Salary (bands of £5,000)	Expense payments (taxable) to nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
Raj Jain	Chair	55 - 60	-	-	-	-	55 - 60
Tony Foy	Non-Executive Director	15 - 20	300	-	-	-	15 - 20
Erica Morris	Non-Executive Director	10 - 15	300	-	-	-	10 - 15
Neil Large MBE	Non-Executive Director	15 - 20	500	-	-	-	15 - 20
Hilary Garrett CBE (from 18 January 2023)	Non-Executive Director	0 - 5	-	-	-	-	0 - 5
Dr Naomi Rankin	Partner Member	0 - 5	-	-	-	-	0 - 5
Adam Irvine	Partner Member	5 - 10	-	-	-	-	5 - 10
Professor Stephen Broomhead MBE	Partner Member	-	-	-	-	-	-
Cllr Paul Cummins	Partner Member	5 - 10	-	-	-	-	5 - 10
Ann Marr OBE	Partner Member	-	-	-	-	-	-
Joe Rafferty CBE	Partner Member	-	-	-	-	-	-
Graham Urwin	Chief Executive	190 - 195	-	-	-	-	190 - 195
Claire Wilson	Executive Director of Finance	130 - 135	-	-	-	180 - 182.5	310 - 315
Professor Rowan Pritchard-Jones	Medical Director	130 - 135	-	-	-	147.5 - 150	275 - 280
Christine Douglas MBE (from 1 August 2022)	Executive Director of Nursing and Care	110 - 115	-	-	-	-	110 - 115
Marie Boles (from 1 July 2022 to 31 August 2022)	Interim Executive Director of Nursing and Care	35 - 40	-	-	-	-	35 - 40

**Notes: Taxable expenses and benefits in kind are expressed to the nearest £100.

a) The Chief Executive, Executive Director of Finance, Executive Director of Nursing and Care and Executive Medical Director are engaged under contracts of services and are employees.

b) The value of pension benefits accrued during the period is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. The value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

c) NHS Cheshire and Merseyside existed in shadow form from 1 April 2022. Non-Executive members Neil Large (£0-5k), Tony Foy (£0-5k) and Erica Morris (£0-5k) were appointed on 1 July 2022 and were remunerated by NHS Cheshire and Merseyside for the period 1 April 2022 to 30 June 2022. This remuneration has been included table.

d) NHS Cheshire and Merseyside existed in shadow form from 1 April 2022. Raj Jain was appointed on 1 July 2022 and was remunerated by NHS Cheshire CCG (£15-20k) for work in the shadow form period. That remuneration is not included in the table above as it was paid by another party.

e) Marie Boles was appointed as interim Executive Director of Nursing and Care for the period 1 July 2022 - 30 August 2022 on a secondment basis from NHS England. The above table represents the basic salary recharged to NHS Cheshire and Merseyside which includes the period 1 March 2022 to 30 June 2022 (£15-20k).

f) Anne Marr OBE, Joe Rafferty CBE and Professor Steven Broomhead MBE are Partner Board Members and are not remunerated by NHS Cheshire and Merseyside.

g) Claire Wilson received £0-£5k for work carried out prior to the establishment of NHS Cheshire and Merseyside. The remuneration for this has been included in the table above.

2.3.1.6 Pension benefits as at 31 March 2023 (Subject to Audit)

All salaried Board members, except for our Non-Executive members, had access to the NHS Pension Scheme. Details of each pension scheme can be found online.[43]

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age 31 March 2023 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 July 2022	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2023	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Professor Rowan Pritchard-Jones – Medical Director	7.5 - 10	15 - 17.5	50 - 55	105 - 110	718	121	872	-
Claire Wilson – Executive Director of Finance	7.5 - 10	17.5 - 20	45 - 50	105 - 110	630	139	801	-

a) The pension entitlement above is the total pension entitlement for each Board member and is not reduced for the effect contributions made as a result of contributions made in employment for other entities.

b) Cash Equivalent Transfer Values at 1 July 2022 have been recalculated to include 3.1% inflation which is calculated in accordance with SI 2008 No. 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008 (33)

c) Cash equivalent transfer values: A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

d) Real Increase in Cash Equivalent Transfer Value is the increase in CETV that is funded by the Employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

e) Graham Urwin chose not to be covered by the pension arrangements during the reporting year. Christine Douglas is retired from the NHS Pension Scheme.

f) NHS Cheshire and Merseyside was in operation from 1 July 2022 to 31 March 2023. As such the real increase figures have been apportioned to reflect the period it has been in operation.

[43]https://www.nhsbsa.nhs.uk/member-hub

2.3.1.7 Compensation on early retirement or for loss of office

There were no payments for compensation on early retirement or for loss of office in 2022-23.

2.3.1.8 Payments to past directors

No payments have been made to past senior managers in 2022-23.

2.3.1.9 Exit Packages

There were no exit packages for members of the Board. Exit packages for other staff are set out in the staff report.

2.3.2 Staff Report

2.3.2.1 Number of senior managers and gender split

At 31 March 2023, NHS Cheshire and Merseyside employed the following staff including 30 senior managers on a Very Senior Manager contract.

	Headcount by Gender		
Staff Grouping	**Female**	**Male**	**Totals**
Board (including office holders)	6	9	**15**
Other Senior Management (Band 8C+)	107	61	**168**
All Other Employees	679	173	**852**
Grand Total	**792**	**243**	**1035**

The percentage split by gender was as follows:

	% by Gender	
Staff Grouping	**Female**	**Male**
Board (including office holders)	40.0%	60.0%
Other Senior Management (Band 8C+)	63.7%	36.3%
All Other Employees	79.7%	20.3%
Grand Total	**76.52%**	**23.48%**

2.3.2.2 Staff numbers and costs (subject to audit)

Average staffing numbers by occupation can be summarised in the following table:

Staff Grouping	Permanent	Other
Administrative and Estates	611	60
Medical and Dental	16	-
Nursing and Midwifery	117	20
Scientific/ Therapeutic / Technical	117	30
Total	**987**	**110**

Total staffing costs are summarised in the following table:

	Permanent Employees £000s	Other £000s	Total £000s
Salaries and wages	36,342	1,726	38,068
Social security costs	4,430	-	4,430
Employer contributions to the NHS Pension Scheme	6,738	-	6,738
Other pension costs	19	-	19
Apprenticeship Levy	175	-	175
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	319	-	319
Gross Employee Benefits Expenditure	**48,023**	**1,726**	**49,749**

A breakdown of staff Headcount by band at 31 March 2023 was:

Pay Band	**Headcount**
Band 2	9
Band 3	44
Band 4	69
Band 5	111
Band 6	137
Band 7	208
Band 8A	144
Band 8B	130
Band 8C	49
Band 8D	22
Band 9	35
Medical	43
VSM	34
Board (Off Payroll)	0
Total	**1,035**

2.3.2.3 Sickness absence data

The sickness absence data for NHS Cheshire and Merseyside in the calendar year 2022 was whole time equivalent (WTE) days available of 214,911 and WTE days lost to sickness absence of 6,482 and average working days lost per employee was 6.79 which was managed through the absence management policy.

Staff sickness absence 2022	**Number**
Total days lost	6,482
Total staff years	955
Average working days lost	6.79

2.3.2.4 Staff turnover percentages

NHS Cheshire and Merseyside's Staff Turnover Rate for 2022-23 has been calculated by dividing the total FTE Leavers in-year by the average FTE Staff in Post during the year. The Total FTE Leavers in year was 127.97. The Average FTE Staff in Post during the year was 948.45. The Staff Turnover Rate for the year was 13.49%.

This is included in the table below:

Staff turnover	**Number**
Average FTE employed	948.45
Total FTE leavers	127.97
Turnover rate	13.49%

Throughout the period NHS Cheshire and Merseyside's staff turnover rate was reported regularly to its Board and Executive Team. Workforce data provided to NHS Cheshire and Merseyside by Midlands and Lancashire Commissioning Support Unit outlined all recorded reasons for staff leaving NHS Cheshire and Merseyside with the top four reasons (in 2022-23) being:

- Voluntary resignation - work life balance
- Voluntary resignation – promotion
- Retirement age
- End of fixed term contract - end of work requirement.

2.3.2.5 Staff Survey

NHS Cheshire and Merseyside undertook the national staff survey during the period September to November 2022. As a new organisation, there was no mandated requirement in year one to undertake the survey however NHS Cheshire and Merseyside felt it was important to participate to ascertain staff opinion and establish a baseline of staff views for future benchmarking and comparison. The national staff survey follows an agreed format with questions aligned to areas of the NHS People Promise, staff engagement and morale. Using an independent national survey provider, NHS Cheshire and Merseyside achieved a positive response rate of 65% with a significant number of staff responding with free text comments.

Our results against the seven areas of the NHS People Promise are detailed below:

	People Promise Area	**Score (out of 10)**
1	We are compassionate and inclusive	7.55
2	We work flexibly	7.21
3	We are a team	7.16
4	We have a voice that counts	6.85
5	We are recognised and rewarded	6.52
6	We are safe and healthy	6.39
7	We are always learning	5.27

Paying particular attention to the key themes of the survey, NHS Cheshire and Merseyside's staff engagement score is 6.72 (made up of questions in respect of motivation, involvement and advocacy) and staff morale (made up of questions in respect of stressors, work pressures and staff who are considering leaving) is 5.73.

In response to the prior publication of the results, NHS Cheshire and Merseyside established a staff survey engagement group made up of representatives from all teams to review the results, start to identify key areas of development and ensure effective mechanisms for ongoing sharing, listening and feedback.

There were a number of areas where NHS Cheshire and Merseyside scored positively against sector comparisons. This was particularly linked to relationships, connections and working arrangements within teams. NHS Cheshire and Merseyside is also pleased to report that it scored positively against peer organisations in respect of lower incidences of bullying, harassment and discrimination. Work will continue to take further develop and embed these areas of strength.

In relation to areas of development and improvement, NHS Cheshire and Merseyside has identified six key work programmes to take forward during 2023-24. These are detailed below:

- Developing our approach to staff recognition and celebration
- Supporting the development and promotion of our health and wellbeing offer
- Developing approaches to retention
- Developing our learning and organisational development frameworks
- Reviewing capacity and working practices
- Implementing a framework for engagement and involvement.

Results were shared and discussed widely as part of our "we are one" staff communications mechanism and via localised staff engagement forums. An organisational action plan was launched in April 2023 with regular monitoring and reporting arrangements for staff and through assurance mechanisms. A newly established Staff Engagement Group also takes a lead role in the development and implementation of the various work programmes. To support the organisation in the development of its internal work programmes, a new Head of Staff Experience, Engagement and Wellbeing was appointed in January 2023 to lead the various strands of this work.

2.3.2.6 Staff policies

NHS Cheshire and Merseyside is committed to creating an environment in which people can feel valued, where people are treated fairly and with dignity and respect. As part of NHS Cheshire and Merseyside's establishment, all HR policies were reviewed, and a single set of policies adopted from 1 July 2022. NHS Cheshire and Merseyside has developed a policy review schedule to ensure all staff policies are regularly reviewed and this is done in partnership with staff side colleagues. NHS Cheshire and Merseyside conducts Equality Impact Analysis for all strategies, policies and processes to ensure it treats people fairly and does not undermine their rights.

NHS Cheshire and Merseyside is committed to creating an environment that promotes equality and embraces diversity in its performance as an employer. It adheres to legal and performance requirements and mainstreams its equality and diversity principles through its policies, procedures and processes. Policies are equality impact assessed during the policy development processes to ensure that our policies do not have an adverse impact in response to the requirements of The Equality Act 2010. NHS Cheshire and Merseyside will take action when necessary to address any unexpected or unwarranted disparities and monitor workforce and employment practices to ensure that employment policies are fairly implemented.

NHS Cheshire and Merseyside has a Recruitment and Selection Policy which aims to ensure compliance with current legislation for employing staff in accordance with the Equality Act, Immigration Rules and the Disclosure and Barring Service (as applicable). It operates a fair and objective system for recruiting, which places emphasis on individual skills, abilities and experience. Selection criteria contained within our Job Descriptions and Person Specifications are reviewed to ensure that they are justifiable and so do not unfairly discriminate directly or indirectly and are essential for the effective performance of the role. NHS Cheshire and Merseyside is positive about employing people with disabilities and all applicants who declare that they have a disability and who meet the essential criteria for a post are shortlisted and invited to interview. We are committed to making reasonable adjustments in the workplace, including appropriate training, to support the continuation of employment. Recruitment and selection training is available for managers and regular support, advice and guidance is provided to recruiting managers by the Recruitment Team.

We strive to enable all staff to achieve their full potential in an environment of dignity and mutual respect. Support for staff who become disabled is provided under the Management of Attendance Policy and Performance Management Policy. Where medical advice recommends temporary or permanent changes, managers will consider how we can support our employees to continue in their present role or where more appropriate to an alternative role. Redeployment may be on a temporary or permanent basis depending on the needs of the individual and the requirements of the role.

NHS Cheshire and Merseyside is committed to ensuring that its education, training and development offer is accessible to all and currently offers a range of learning opportunities through Midlands and Lancashire CSU.

2.3.2.7 Equality, Diversity and Human Rights

Gender Pay Gap (GPG) is a statutory requirement for all NHS organisations who have 250 or more staff. The Gender Pay Gap results are an important driver of our equality and inclusion activity in relation to improving gender equality. NHS Cheshire and Merseyside will need to prepare for gender pay gap reporting for 2023-24. Currently, the NHS Cheshire and Merseyside profile for gender representation across senior pay bands can be viewed in the NHS Cheshire and Merseyside EDI Annual report[44].

Workforce Race Equality Standard (WRES) - NHS Cheshire and Merseyside is required to participate in the WRES data return (August 2023) and publish its report and action plan in October 2023. The nine WRES indicators cover recruitment and pay; access to training; disciplinary; discrimination, bullying and harassment and NHS Cheshire and Merseyside Board membership. The current NHS Cheshire and Merseyside ethnicity profile can be viewed in section 7 of the EDI Annual Report[45].

The main purpose of the WRES as outlined by NHS England is to:

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

The Workforce Disability Equality Standard (WDES) is a data-based standard that uses a series of measures to improve the experiences of disabled staff in the NHS. The WDES was mandated by the NHS Standard Contract and became applicable to all NHS trusts and foundation trusts in April 2019.

Mandatory reporting on WDES is restricted to NHS trusts and foundation trusts however, in accordance with its commitment to best practice beyond compliance, NHS Cheshire and Merseyside will review its workforce disability data for the first

[44] https://www.cheshireandmerseyside.nhs.uk/media/exfj0lgi/nhscm-annual-edi-report-2324-final-3323.pdf
[45] https://www.cheshireandmerseyside.nhs.uk/media/exfj0lgi/nhscm-annual-edi-report-2324-final-3323.pdf

time in 2023. Current NHS Cheshire and Merseyside disability representation profile and can be viewed in the EDI Annual Report[46].

An inclusive culture sits at the heart of NHS Cheshire and Merseyside. In July 2022, NHS Cheshire and Merseyside developed a 'culture code' to define the behavioural operating principles to support organisational identity.

2.3.2.8 Trade Union Facility Time Reporting Requirements

The Trade Union (Facility Time Publication Requirements) Regulations 2017 which took effect from 1 April 2017, require all public-sector organisations that employ more than 49 full-time employees, and have at least one trade union representative, to submit data relating to the use of facility time in their organisation.

Facility time is paid time-off during working hours for trade union representatives to carry out trade union duties. The reporting period is 1 April to 31 March with submissions due by 31 July.

Reporting covering the period 1 April 2022 to 31 March 2023 will be published on the NHS Cheshire and Merseyside website by 31 July 2023 as per statutory regulations.

2.3.2.9 Consulting with staff

NHS Cheshire and Merseyside utilises the Staff Partnership Forum facilitated by Midlands and Lancashire CSU to discuss a range of issues affecting staff. It is recognised that NHS Cheshire and Merseyside has undergone a significant period of organisational change and has sought to engage with staff in local meetings and hold additional extra meetings to consult, discuss, debate and inform staff where changes are planned that impact on them directly.

2.3.2.10 Expenditure on consultancy

Consultancy is the provision to management of objective advice and assistance relating to strategy, structure, management or operations of an organisation in pursuit of its purposes and objectives. Such assistance will be provided outside the 'business as-usual' environment when in-house skills are not available and will be of no essential consequence and time-limited. Consultancy may include the identification of options with recommendations, or assistance with (but not delivery of) the implementation of solutions.

During the nine months ending 31 March 2023, £535k was spent on external consultancy comprising:

- £273k for work relates to a review of clinical services for the Liverpool system

[46] https://www.cheshireandmerseyside.nhs.uk/media/exfj0lgi/nhscm-annual-edi-report-2324-final-3323.pdf

- £150k for an independent financial review of the key drivers of deficits for a large hospital trust and
- £112k on other reviews of clinical spend and on the development of Corporate Governance Frameworks.

2.3.2.11 Off-payroll engagements

Off payroll engagements are payments made by NHS Cheshire and Merseyside to employees outside of its payroll system that are for more than £245 per day and that last for longer than six months.

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31 March 2023 for more than £245* per day:

	Number
Number of existing engagements as of 31 March 2023	55**
Of which, the number that have existed:	
for less than 1 year at the time of reporting	55
for between 1 and 2 years at the time of reporting	-
for between 2 and 3 years at the time of reporting	-
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	-

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

** Comprises 17 agency workers, 38 clinical leads.

Existing off payroll engagements have been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and where necessary, that assurance has been sought.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2022 and 31 March 2023, for more than £245* per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2022 and 31 March 2023	41
Of which:	
No. not subject to off-payroll legislation	-
No. subject to off-payroll legislation and determined as in-scope of IR35	8
No. subject to off-payroll legislation and determined as out of scope of IR35	33
the number of engagements reassessed for compliance or assurance purposes during the year	-
Of which: no. of engagements that saw a change to IR35 status following review	-

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2022 and 31 March 2023:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period	-
Total no. of individuals on-payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on-payroll and off-payroll engagements.	16

2.3.2.12 Exit packages, including special (non-contractual) payments

Table 1: Exit Packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
£150,001 – £200,000	3	480,000						
>£200,000								
TOTALS	3	480,000						

Redundancy and other departure cost have been paid in accordance with the terms Agenda for Change Terms and Conditions. Exit costs in this note are accounted for in full in the year of departure. Where NHS Cheshire and Merseyside has agreed early retirements, the additional costs are met by NHS Cheshire and Merseyside and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

None of the exit packages included amounts for other departures.

2.3.2.13 Parliamentary Accountability and Audit Report

NHS Cheshire and Merseyside is not required to produce a Parliamentary Accountability and Audit Report.

An audit certificate and report is also included in this Annual Report at pages 143 to 150. The auditor's report is in respect of the matters described in that report and hyperlinks included in the report and accounts are not audited by the auditors (Grant Thornton) unless expressly stated.

Graham Urwin

Graham Urwin

Accountable Officer

29 June 2023

Independent auditor's report to the members of the Board of NHS Cheshire and Merseyside Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Cheshire and Merseyside Integrated Care Board (the 'ICB') for the period ended 31 March 2023, which comprise the Statement of Comprehensive Net Expenditure for the nine months ended 31 March 2023, the Statement of Financial Position as at 31 March 2023, the Statement of Changes in Taxpayers Equity for the nine months ended 31 March 2023, the Statement of Cash Flows for the nine months ended 31 March 2023 and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2023 and of its expenditure and income for the period then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2022-23 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report and accounts, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report and accounts. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022-23; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial period for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 94 to 95, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).
- We enquired of management and the audit committee, concerning the ICB's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the ICB’s financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - Large and unusual journal entries, particularly those entered around or after the period-end or reducing expenditure.
  - The accuracy of the prescribing accrual.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on large and unusual items and those falling within identified risk criteria including; material journals, journals posted by senior management, period-end journals, journals posted after 31 March 2023, period-end accruals,self-approved journals and journals reducing expenditure at the period-end;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of prescribing;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to the prescribing accrual.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the ICB operates
  - understanding of the legal and regulatory requirements specific to the ICB including:
    - the provisions of the applicable legislation
    - NHS England’s rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The ICB’s operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities . This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 31 March 2023.

Our work on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the ICB's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the period ended 31 March 2023.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibilities for the review of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the ICB plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the ICB has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Cheshire and Merseyside Integrated Care Board for the period ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the members of the Board of Cheshire and Merseyside Integrated Care Board, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Board of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Board of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

Michael Green

Michael Green, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Manchester

29 June 2023

Independent auditor's report to the members of the Board of NHS Cheshire and Merseyside Integrated Care Board

In our auditor's report issued on 29 June 2023, we explained that we could not formally conclude the audit and issue an audit certificate for NHS Cheshire and Merseyside Integrated Care Board (the 'ICB') for the period ended 31 March 2023, in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice, until we had completed our work on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the period ended 31 March 2023 issued on 29 June 2023 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2023 and of its expenditure and income for the period then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

No matters have come to our attention since 29 June 2023 that would have a material impact on the financial statements on which we gave this opinion.

Report on other legal and regulatory requirements - the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 31 March 2023.

We have nothing to report in respect of the above matter except on 5 September 2023 we identified a significant weakness in the ICB's arrangements for financial sustainability. This was in relation to the financial sustainability of the system as the ICB has a leadership role in managing the NHS budget across the health system and in co-ordinating financial plans in order to deliver statutory financial duties. The Cheshire and Merseyside health system is complex and submitted a deficit financial plan for 2023/24. We recommended that the ICB should continue to work with system partners as a priority to develop a medium-term financial plan for the whole Cheshire and Merseyside Integrated Care System and that the ICB should continue to work with partners to develop the system wide efficiency programme.

Responsibilities of the Accountable Officer

The Accountable Officer of the ICB is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibilities for the review of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the ICB plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the ICB has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of NHS Cheshire and Merseyside Integrated Care Board for the period ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Board of the ICB, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Board of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Board of the ICB, as a body, for our audit work, for this report, or for the opinions we have formed.

Michael Green

Michael Green, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Manchester

15 September 2023

NHS Cheshire and Merseyside ICB - Accounts for the nine months ended 31 March 2023

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the nine months ended 31 March 2023

	Note	Nine months ended 31 March 2023 £'000
Income from sale of goods and services	2	(31,616)
Other operating income	2	(269)
Total operating income		**(31,885)**
Staff costs	4	49,749
Purchase of goods and services	5	4,549,011
Depreciation and impairment charges	5	904
Provision expense	5	(1,379)
Other Operating Expenditure	5	3,835
Total operating expenditure		**4,602,120**
Net Operating Expenditure		**4,570,235**
Finance income		-
Finance expense		33
Net expenditure for the period		**4,570,268**
Net (Gain)/Loss on Transfer by Absorption	9	413
Comprehensive Expenditure for the period		**4,570,681**

Notes 1 to 25 form part of these financial statements.

Statement of Financial Position as at 31 March 2023

	Note	31 March 2023 £'000	01 July 2022 £'000
Non-current assets:			
Property, plant and equipment	10	510	739
Right-of-use assets	10a	2,777	3,052
Intangible assets	11	12	94
Total non-current assets		**3,300**	3,885
Current assets:			
Trade and other receivables	12	50,775	44,782
Cash and cash equivalents	13	1	-
Total current assets		**50,776**	**44,782**
Total current assets		**50,776**	44,782
Total assets		**54,076**	48,667
Current liabilities			
Trade and other payables	14	(390,913)	(368,148)
Lease liabilities	10a	(672)	(759)
Borrowings	13	(3,783)	(3,056)
Provisions	15	-	(1,542)
Total current liabilities		**(395,369)**	(373,505)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(341,293)**	(324,838)
Non-current liabilities			
Lease liabilities	10a	(2,068)	(2,252)
Total non-current liabilities		**(2,068)**	**(2,252)**
Assets less Liabilities		**(343,361)**	(327,090)
Financed by Taxpayers' Equity			
General fund		(343,361)	(327,090)
Total taxpayers' equity:		**(343,361)**	(327,090)

Notes 1 to note 25 form part of these financial statements.

The financial statements on pages 149 to 174 were approved by the Board on 29 June 2023 and signed on its behalf by:

Graham Urwin

Graham Urwin
Chief Executive
Date: 29 June 2023

Statement of Changes In Taxpayers Equity for the nine months ended 31 March 2023

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 31 March 2023		
Balance at 1 July 2022	-	-
Transfer between reserves in respect of assets transferred from closed NHS bodies	(327,090)	(327,090)
Adjusted NHS Clinical Commissioning Group balance at 1 July 2022	**(327,090)**	**(327,090)**
Changes in NHS ICB taxpayers' equity for 31 March 2023		
Total transition adjustment for initial application of IFRS 16	-	**-**
Net operating expenditure for the financial period	(4,570,268)	(4,570,268)
Transfers by modified absorption to (from) NHS England	(413)	(413)
Net Recognised NHS ICB Expenditure for the Financial period	**(4,570,681)**	**(4,570,681)**
Net funding	4,554,410	**4,554,410**
Balance at 31 March 2023	**(343,361)**	**(343,361)**

Notes 1 to note 25 form part of these financial statements.

Statement of Cash Flows for the nine months ended 31 March 2023

	Note	31 March 2023 £'000
Cash Flows from Operating Activities		
Net expenditure for the financial year		(4,570,235)
Depreciation and amortisation	5	905
Movement due to transfer by Modified Absorption		(413)
Other Gains & Losses		14
(Increase)/decrease in trade & other receivables	12	(5,993)
Increase/(decrease) in trade & other payables	14	22,765
Provisions utilised	15	(3)
Increase/(decrease) in provisions	15	(1,539)
Net Cash Inflow (Outflow) from Operating Activities		**(4,554,499)**
Cash Flows from Investing Activities		
Proceeds from disposal of assets held for sale: property, plant and equipment		(14)
Net Cash Inflow (Outflow) from Investing Activities		**(14)**
Net Cash Inflow (Outflow) before Financing		**(4,554,514)**
Cash Flows from Financing Activities		
Grant in Aid Funding Received		4,554,410
Repayment of lease liabilities including interest		(623)
Net Cash Inflow (Outflow) from Financing Activities		**4,553,787**
Net Increase (Decrease) in Cash & Cash Equivalents	13	**(726)**
Cash & Cash Equivalents transferred on 1 July 2022		**(3,056)**
Cash & Cash Equivalents (including bank overdrafts) at 31 March 2023		**(3,782)**

Notes 1 to note 25 form part of these financial statements.

Notes to the financial statements

1. Accounting Policies

NHS England has directed that the financial statements of NHS Cheshire & Merseyside Integrated Care Board (the ICB) shall meet the accounting requirements of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC Group Accounting Manual 2022-23, issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021. The Act allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCG). ICBs took on the commissioning functions of CCGs. The CCG functions, assets and liabilities were transferred to an ICB on 1 July 2022.

1.1 Going concern

These accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention, modified to account for the revaluation of property, plant and equipment, intangible assets, and certain financial assets and financial liabilities.

1.3 Joint arrangements

Arrangements over which the ICB has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.
A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the ICB is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.
The pooled budget arrangements (Note 21) under Section 75 arrangements with local authorities are joint arrangements because the agreements set out shared control of the arrangements.

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.4.1 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- assessment of Right of Use assets and liabilities for inclusion as a result of the implementation of IFRS 16 including the judgements that assets used by the ICB should be capitalised and a consequent liability recognised and that assets that the ICB funds for third parties where no right of use of the asset for the ICB exists are not capitalised but the funding is accounted for as a funding expenditure for the relevant services.

1.4.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- Certain right of use property does not have fully documented leases but the ICB expects that they will have a continuing right to use such properties until notice is given to the holder of the lease. Management has estimated the lease length for such arrangements based upon the expected period which the ICB estimates it will occupy those properties.

1.5 Transfer of functions

As public sector bodies are deemed to operate under common control, business reconfigurations within the DHSC group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the GAM requires the application of 'absorption accounting'. Absorption accounting requires that entities account for their transactions in the period in which they took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

For transfers of assets and liabilities from those bodies that closed on 30 June 2022 a modified absorption approach is applied. For these transactions only, gains and losses are recognised in reserves through the Statement of Changes in Taxpayers Equity rather than the Statement of Comprehensive Net Expenditure. Details of assets transferred from the ICB's predecessor CCG organisations are set out in Note 9.

1.6 Pooled budgets

The ICB has entered into pooled budget arrangements with local authorities in Cheshire and Merseyside in accordance with section 75 of the NHS Act 2006. Under the arrangements, funds are pooled for Better Care Funds with local authorities in which a programme is funded to deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. Note 21 provides details of the schemes and the expenditure.

The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budgets, identified in accordance with the pooled budget agreement.

1.7 Operating segments

All operating segments carry out commissioning of healthcare services and consequently, as allowed under IFRS 8, these are reported in aggregate.

1.8 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are:

· the ICB is not required to disclose information regarding performance obligations that are part of a contract that has an original expected duration of one year or less,

· the ICB is not required to disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with value of the performance completed to date.

· The FReM has mandated the exercise of the practical expedient offered in the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the ICB is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles. Significant terms include all amounts being due within thirty days of the invoice.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.9 Employee Benefits

1.9.1 Short-term employee benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees. There is no performance pay.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period. At 31 March 2023 this was estimated to be £372k.

1.9.2 Retirement benefit costs

NHS Pensions

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the ICB of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Some employees are members of National Employment Savings Trust, which is a defined contribution pension scheme. The cost to the ICB of participating in the scheme is the contributions payable to the scheme for the accounting period.

1.10 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.11 Value added tax

Most of the activities of the ICB are outside the scope of value added tax (VAT). Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.12 Property, plant and equipment

1.12.1 Recognition

Property, plant and equipment is capitalised if:

· it is held for use in delivering services or for administrative purposes
· it is probable that future economic benefits will flow to, or service potential will be supplied to the ICB
· it is expected to be used for more than one financial year
· the cost of the item can be measured reliably, and either
· the item has cost of at least £5,000, or

· collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control. Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their individual useful economic lives.

1.12.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.
Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive net expenditure in the Statement of Comprehensive Net Expenditure.

1.12.3 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.13 Intangible assets

1.13.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the ICB's business or which arise from contractual or other legal rights. They are recognised only:

- when it is probable that future economic benefits will flow to, or service potential be provided to, the ICB;
- where the cost of the asset can be measured reliably; and
- where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.
Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it, and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.13.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.
Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.14 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straightline basis over their estimated useful lives. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.
Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the ICB expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

At each financial year end, the ICB checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.
Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

1.15 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16.

The ICB is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 the ICB has assessed that in all other respects these arrangements meet the definition of a lease under the Standard.
The ICB is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

1.16.1 The ICB as lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. The ICB employs a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Lease payments are apportioned between finance charges and repayment of the principal. Finance charges are recognised in the Statement of Comprehensive Net Expenditure.

Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Where there is a change in a lease term or an option to purchase the underlying asset the ICB applies a revised rate to the remaining lease liability.

Where existing leases are modified the ICB must determine whether the arrangement constitutes a separate lease and apply the Standard accordingly.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less, or is elected as a lease containing low value underlying asset by the ICB.

1.17 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management. Cash, bank and overdraft balances are recorded at current values.

1.18 Provisions

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of 1.70% (2021-22: negative 1.30%) in real terms

1.19 Clinical negligence costs

NHS Resolution (the trading name of the NHS Litigation Authority NHSLA) operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the ICB.

1.20 Non-clinical risk pooling

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.21 Contingent liabilities and contingent assets

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation, or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.22 Financial assets

Financial assets are recognised when the ICB becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the ICB has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets are classified into the following categories:

- Financial assets at amortised cost,
- financial assets at fair value through other comprehensive income, and
- financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.22.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.22.2 Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.22.3 Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.22.4 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the ICB recognises a loss allowance representing expected credit losses on the financial instrument.

The ICB adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

Lifetime credit losses for Non Government trade receivables are determined by applying a percentage representing lifetime expected losses depending on the age of the debt. For example, debts greater than 90 days old have a expected credit loss of 10.6%.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.23 Financial liabilities

Financial liabilities are recognised when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished – that is, the obligation has been discharged or cancelled or has expired.

1.23.1 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

1.24 Foreign currencies

The ICB's functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Net Expenditure in the period in which they arise.

1.25 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.26 IFRS Standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2022-23. These Standards are still subject to HM Treasury FReM adoption.

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 is yet to be adopted by the FReM, therefore early adoption is not permitted.

The application of the Standards as revised would not have a material impact on the accounts for 2022-23, were they applied in that year.

2. Other Operating Revenue

	Nine months ended 31 March 2023 £'000
Income from sale of goods and services (contracts)	
Education, training and research	**135**
Non-patient care services to other bodies	**3,581**
Prescription fees and charges	**27,288**
Other Contract income	**612**
Total Income from sale of goods and services	**31,616**
Other operating income	
Charitable and other contributions to revenue expenditure: non-NHS	**143**
Non cash apprenticeship training grants revenue	**126**
Total Other operating income	**269**
Total Operating Income	**31,885**

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the general reserve.

3. Disaggregation of Income - Income from sale of good and services (contracts)

Nine months ended 31 March 2023

	Education, training and research £'000	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Other Contract income £'000
Source of Revenue				
NHS	135	1,569	-	-
Non NHS	-	2,012	27,288	612
Total	**135**	**3,581**	**27,288**	**612**

	Education, training and research £'000	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Other Contract income £'000
Timing of Revenue				
Point in time	135	3,190	27,288	612
Over time	-	391	-	-
Total	**135**	**3,581**	**27,288**	**612**

4. Employee benefits and staff numbers

4.1 Employee benefits

	Total		Nine months ended 31 March 2023
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	36,342	1,726	**38,068**
Social security costs	4,430	-	**4,430**
Employer Contributions to NHS Pension scheme	6,738	-	**6,738**
Other pension costs	19	-	**19**
Apprenticeship Levy	175	-	**175**
Termination benefits	319	-	**319**
Gross employee benefits expenditure	**48,023**	**1,726**	**49,749**

4.2 Average number of people employed

	Nine months ended 31 March 2023		
	Permanently employed Number	Other Number	Total Number
Total	**861**	**110**	**971**

No staff were engaged on capital projects in 2022-23

4.3 Exit packages agreed in the financial year

	Nine months ended 31 March 2023 Compulsory redundancies		Nine months ended 31 March 2023 Other agreed departures		Nine months ended 31 March 2023 Total	
	Number	£	Number	£	Number	£
£150,001 to £200,000	3	480,000	-	-	3	480,000
Total	**3**	**480,000**	**-**	**-**	**3**	**480,000**

This table reports the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy costs have been paid in accordance with the provisions of the terms and conditions set out in Agenda for Change.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

5. Operating expenses

	Nine months ended 31 March 2023 £'000
Purchase of goods and services	
Services from other ICBs, CCGs and NHS England	10,269
Services from foundation trusts	2,324,808
Services from other NHS trusts	677,291
Purchase of healthcare from non-NHS bodies	556,328
Purchase of social care	72,620
Prescribing costs	397,982
Pharmaceutical services	79,873
General Ophthalmic services	319
GPMS/APMS and PCTMS	389,399
Supplies and services – clinical	1,723
Supplies and services – general	10,055
Consultancy services	535
Establishment	10,842
Transport	22
Premises	13,041
Audit fees	552
Other non statutory audit expenditure	
· Other services	158
Other professional fees	1,737
Legal fees	819
Education, training and conferences	512
Non cash apprenticeship training grants	126
Total Purchase of goods and services	**4,549,010**
Depreciation and impairment charges	
Depreciation	825
Amortisation	79
Total Depreciation and impairment charges	**904**
Provision expense	
Provisions	(1,378)
Total Provision expense	**(1,378)**
Other Operating Expenditure	
Chair and Non Executive Members	185
Grants to Other bodies	3,058
Research and development (excluding staff costs)	1,662
Expected credit loss on receivables	(1,134)
Other expenditure	64
Total Other Operating Expenditure	**3,835**
Total operating expenditure	**4,552,371**

Audit fees of £552k relate to ICB only and include Value Added Tax. 'Other non statutory audit expenditure - other services' includes fees in relation to the Mental Health Investment Standard (MHIS) audits and minor adjustments relating to audit services provided to the ICB's predecesor CCGs.

In accordance with SI 2008 no.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, where a CCG contract with its auditors provides for a limitation of the auditor's liability, the principal terms of this limitation must be disclosed. The contract for the provision of external audit services is held by Grant Thornton UK LLP. This limitation has been confirmed as £2 million. The external audit fees include Value Added Tax (VAT).

Internal audit services during the year were provided by Mersey Internal Audit Agency and hosted by Liverpool University Hospitals NHS Foundation Trust.

NHS Cheshire and Merseyside ICB - Accounts for the nine months ended 31 March 2023

6. Better Payment Practice Code

Measure of compliance	Nine months ended 31 March 2023 Number	Nine months ended 31 March 2023 £'000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the period	117,419	1,152,253
Total Non-NHS Trade Invoices paid within target	115,390	1,113,844
Percentage of Non-NHS Trade invoices paid within target	**98.27%**	**96.67%**
NHS Payables		
Total NHS Trade invoices paid in the period	3,356	3,077,151
Total NHS Trade Invoices paid within target	3,316	3,070,353
Percentage of NHS Trade Invoices paid within target	**98.81%**	**99.78%**
Amounts included in finance costs from claims made under this legislation		-

The Better Payment Practice Code requires the ICB to aim to pay all valid invoices by the due date or within 30 days of the receipt of a valid invoice, whichever is later. The Better Payment Practice Code sets out target compliance of 95%.

7. Other gains and losses

	£'000
Gain/(loss) on disposal of property, plant and equipment assets other than by sale	14
Total	**14**

8. Finance costs

	Nine months to 31 March 2023 £'000
Interest	
Interest on lease liabilities	19
Total interest and total finance costs	**19**

9. Net gain/(loss) on transfer by absorption

The transfer from NHS England Parent Entities is accounted for using absorption accounting and is recognised in the Statement of Comprehensive Net Expenditure.

Transfers of assets and liabilities from those bodies that closed on 30 June 2022 are accounted for using modified absorption accounting. For these transactions only, gains and losses are recognised in reserves through the Statement of Changes in Taxpayers Equity.

	Total £'000	NHS England Parent Entities £'000	NHS England Group Entities (non parent) £'000
Transfer of property plant and equipment	739	-	739
Transfer of Right of Use assets	3,052	-	3,052
Transfer of intangibles	94	-	94
Transfer of receivables	44,782	-	44,782
Transfer of payables	(368,148)	-	(368,148)
Transfer of provisions	(1,542)	-	(1,542)
Transfer of Right Of Use liabilities	(3,011)	-	(3,011)
Transfer of borrowings	(3,056)	-	(3,056)
Transfer of PUPOC liability	(413)	(413)	-
Net loss on transfers by absorption	**(327,503)**	**(413)**	**(327,090)**

10. Property, plant and equipment

31 March 2023	**Buildings excluding dwellings £'000**	**Plant & machinery £'000**	**Information technology £'000**	**Furniture & fittings £'000**	**Total £'000**
Cost or valuation at 1 July 2022	-	-	-	-	-
Transfer (to)/from other public sector body	685	179	2,640	56	3,560
Revised cost or valuation at 1 July 2022	685	179	2,640	56	3,560
Cumulative depreciation adjustment following revaluation	-	-	-	-	-
Cost/Valuation at 31 March 2023	**685**	**179**	**2,640**	**56**	**3,560**
Depreciation 1 July 2022	-	-	-	-	-
Transfer (to)/from other public sector body	297	178	2,290	56	2,821
	297	178	2,290	56	2,821
Charged during the period	103	1	125	0	229
Depreciation at 31 March 2023	**400**	**179**	**2,415**	**56**	**3,050**
Net Book Value at 31 March 2023	**285**	**0**	**225**	**-**	**509**
Purchased	285	0	225	-	510
Total at 31 March 2023	**285**	**0**	**225**	**-**	**510**
Asset financing:					
Owned	285	0	225	-	510
Total at 31 March 2023	**285**	**0**	**225**	**-**	**510**

The ICB inherited property, plant and equipment from legacy CCG's. This included the refurbishment of an administrative building and is disclosed under Buildings excluding dwellings, and various pieces of IT equipment which is disclosed under Information Technology. The remaining economic lives are detailed in note 10.1.

10.1 Economic lives

	Minimum Life (years)	**Maximum Life (Years)**
Buildings excluding dwellings	2	2
Plant & machinery	-	-
Information technology	1	3
Furniture & fittings	-	-

10a. Leases

10a.1 Right-of-use assets

31 March 2023	Buildings excluding dwellings £'000	Total £'000	Of which: leased from DHSC group bodies £000
Cost or valuation at 1 July 2022	-	-	
Transfer (to) from other public sector body	3,250	3,250	2,661
Revised cost or valuation at 1 July 2022	3,250	3,250	2,661
Additions	537	537	537
Disposals on expiry of lease term	(292)	(292)	(292)
Cost/Valuation at 31 March 2023	**3,495**	**3,495**	**2,906**
Depreciation 1 July 2022	-	-	
Transfer (to) from other public sector body	198	198	116
Revised depreciation 1 July 2022	198	198	116
Charged during the year	595	595	350
Disposals on expiry of lease term	(75)	(75)	(75)
Depreciation at 31 March 2023	**718**	**718**	**391**
Net Book Value at 31 March 2023	**2,777**	**2,777**	**2,515**

NBV by counterparty	
Leased from DHSC	2,515
Net Book Value at 31 March 2023	**2,515**

10a.2 Lease liabilities

	31 March 2023 £'000
Lease liabilities at 1 July 2022	-
Additions	(537)
Interest expense relating to lease liabilities	(19)
Repayment of lease liabilities (including interest)	623
Disposals on expiry of lease term	203
Transfer (to) from other public sector body	(3,011)
Lease liabilities at 31 March 2023	**(2,741)**

10a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	31 March 2023	Of which: leased from DHSC group bodies
Within one year	(694)	(469)
Between one and five years	(1,486)	(1,486)
After five years	(644)	(644)
Balance at 31 March 2023	**(2,824)**	**(2,599)**
Effect of discounting	**83**	**82**
Lease liabilities at 31 March 2023	**(2,741)**	**(2,517)**
Balance by counterparty		
Leased from DHSC		(2,599)
Leased from other entities		(142)
Balance as at 31 March 2023		**(2,741)**

10a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

31 March 2023	Nine months to 31 March 2023 £'000
Depreciation expense on right-of-use assets	595
Interest expense on lease liabilities	19
Expense relating to short-term leases	37
	651

10a.5 Amounts recognised in Statement of Cash Flows

	Nine months to 31 March 2023 £'000
Total cash outflow on leases under IFRS 16	623

10.a Leases cont'd

Leases are recognised under the newly adopted leasing standard IFRS 16, applied from 1 April 2022. Under IFRS 16 leases are recognised as a right of use asset with a corresponding lease liability on the Statement of Financial Position. Each lease payment is allocated between a reduction of the liability and the interest expense. The interest expense is charged to the Statement of Comprehensive Net Expenditure over the lease period. The right of use asset is depreciated over the shorter of the asset's useful life and the lease term on a straight line basis. The ICB has applied the exemption for short-term leases (less than 12 months) and low value assets. In these cases, the lease payments associated with them are recognised as an expense in the Statement of Comprehensive Net Expenditure.

As at 31st March 2023 the ICB holds the following leases which fall within the scope of IFRS 16:

Name	Lessor	Use
Bevan House, Nantwich	NHS Property Services	ICB administrative building
1829 Building, Chester	NHS Property Services	ICB administrative building
Magdalen House, Bootle	Sefton Council	ICB administrative building
Lakeside, Warrington	Herbert Street Properties	ICB administrative building
Nutgrove Villa, Huyton	NHS Property Services	ICB administrative building
The Ellis Centre, Huyton	NHS Property Services	Community services building

The ICB also pays for void space, bookable space and subsidies for properties owned and managed by Community Health Partnerships (CHP) and NHS Property Services (NHSPS), and for space occupied by NHS providers in buildings run by CHP and NHSPS. These do not fall within the definition of a lease and as such are not included in this note.

11. Intangible non-current assets

31 March 2023	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 1 July 2022	-	-
Transfer (to)/from other public sector body	755	**755**
Revised cost or valuation at 1 July 2022	755	755
Cost / Valuation At 31 March 2023	**755**	**755**
Amortisation at 1 July 2022	-	-
Transfer (to) from other public sector body	664	**664**
Revised amortisation at 1 July 2022	664	664
Charged during the period	79	**79**
Amortisation At 31 March 2023	**743**	**743**
Net Book Value at 31 March 2023	**12**	**12**
Purchased	12	**12**
Total at 31 March 2023	**12**	**12**

11.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	-	-

The ICB inherited intangible assets from legacy CCG's. These assets will be fully amortised in the year 2023-24 and therefore economic lives are deemed to be nil.

12. Trade and other receivables

	Current 31 March 2023 £'000	01 July 2022 £'000
NHS receivables: Revenue	4,715	3,478
NHS prepayments	7	318
NHS accrued income	5,072	8,164
NHS Contract Receivable not yet invoiced/non-invoice	10	287
NHS Non Contract trade receivable (i.e pass through funding)	16	345
Non-NHS and Other WGA receivables: Revenue	12,806	6,234
Non-NHS and Other WGA prepayments	3,665	9,735
Non-NHS and Other WGA accrued income	17,050	11,154
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	70
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	273	445
Expected credit loss allowance-receivables	(186)	(1,320)
VAT	882	551
Other receivables and accruals	6,465	5,321
Total current and non current	**50,775**	**44,782**
Included above:		
Prepaid pensions contributions	-	-

There were no non-current receivables in 2022-23.

12.1 Receivables past their due date but not impaired

	31 March 2023 DHSC Group Bodies £'000	31 March 2023 Non DHSC Group Bodies £'000
By up to three months	372	3,714
By three to six months	143	1,367
By more than six months	20	3,809
Total	**535**	**8,890**

12.2 Loss allowance on asset classes	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 1 July 2022	-	-	-
Lifetime expected credit losses on trade and other receivables-Stage 2	(186)	-	(186)
Total	**(186)**	**-**	**(186)**

13. Cash and cash equivalents

	31 March 2023 £'000
Balance transferred at 1 July 2022 bank overdraft Government Banking Service	(3,056)
Net change in year	(726)
Balance at 31 March 2023	**(3,782)**
Made up of:	
Cash in hand	1
Cash and cash equivalents as in statement of financial position	**1**
Bank overdraft: Government Banking Service	(3,783)
Total bank overdrafts	**(3,783)**
Cash and cash equivalents including overdrafts at 31 March 2023	**(3,782)**

The bank overdraft shown above is all due within one year and includes BACS payment runs which have been approved in March 2023 but which will be paid from the bank account in April 2023. These outstanding payments therefore give rise to a technical overdraft which is classified as borrowing in accordance with International Financial Reporting Standards.

14. Trade and other payables	31 March 2023 £'000	01 July 2022 £'000
NHS payables: Revenue	7,684	2,695
NHS accruals	50,725	76,059
NHS deferred income	59	-
Non-NHS and Other WGA payables: Revenue	53,562	37,377
Non-NHS and Other WGA accruals	254,757	158,171
Non-NHS and Other WGA deferred income	834	555
Social security costs	744	770
Tax	679	635
Other payables and accruals	21,869	91,886
Total Trade & Other Payables	**390,913**	**368,148**
Total current and non-current	**390,913**	**368,148**
Included in payables are liabilities of people due in future years under arrangements to buy out the liability for early retirement over 5 years	1	1

Other payables include £4.5m outstanding pension contributions at 31 March 2023 (1 July 2022 £4.5M)

There were no non-current payables in 2022-23.

15. Provisions

	Redundancy £'000	Legal Claims £'000	Continuing Care £'000	Total £'000
Balance at 1 July 2022	-	-	-	-
Transfer (to) from other public sector body under absorption	161	3	1,378	**1,542**
	161	3	1,378	1,542
Utilised during the year	-	(3)	-	**(3)**
Reversed unused	(161)	-	(1,378)	**(1,539)**
Balance at 31 March 2023	-	-	-	-

The ICB inherited opening provisions from legacy CCGs. These balances have been reversed unused or utilised during the financial period. Redundancy costs unused has been accounted for as part of termination benefits in note 4.
Provisions related to legal claims and Continuing Care reversed are shown as credits to provisions in note 5.

16. Contingencies

The ICB had no contingencies as at 31 March 2023. At 31 March 2022, £11,520k was included in provions by NHS Resolution in respect of clinical negligence liabilities that arose in previous years.

17. Capital Commitments

The ICB had no capital commitments as at 31 March 2023.

18.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the ICB is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The ICB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the ICB in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the ICB standing financial instructions and policies agreed by the Board. Treasury activity is subject to review by the ICB and internal auditors.

18.1.1 Currency risk

The ICB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The ICB has no overseas operations. The ICB and therefore has low exposure to currency rate fluctuations.

18.1.2 Interest rate risk

The ICB does not ordinarily borrow and therefore has low exposure to interest rate fluctuations.

18.1.3 Credit risk

Because the majority of the ICB's and revenue comes parliamentary funding, the ICB has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

18.1.4 Liquidity risk

The ICB is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The ICB draws down cash to cover expenditure, as the need arises. The ICB is not, therefore, exposed to significant liquidity risks.

18.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

18. Financial instruments cont'd

18.2 Financial assets

	Financial Assets measured at amortised cost 31 March 2023 £'000	Total 31 March 2023 £'000	Financial Assets measured at amortised cost 01 July 2022 £'000	Total 01 July 2022 £'000
Trade and other receivables with NHSE bodies	2,721	2,721	9,248	9,248
Trade and other receivables with other DHSC group bodies	23,675	23,675	13,550	13,550
Trade and other receivables with external bodies	19,826	19,826	11,380	11,380
Cash and cash equivalents	1	1	-	-
Total at 31 March 2023	**46,223**	**46,223**	**34,178**	**35,498**
Non-financial instruments				
NHS prepayments	7	7	318	318
Non-NHS and other WGA Prepayments	3,665	3,665	9,735	9,735
VAT	882	882	551	551
Total current assets as at 31 March 2023 (as per Statement of Financial Position)	**50,776**	**50,776**	**44,782**	**44,782**

18.3 Financial liabilities

	Financial Liabilities measured at amortised cost 31 March 2023 £'000	Total 31 March 2023 £'000	Financial Liabilities measured at amortised cost 01 July 2022 £'000	Total 01 July 2022 £'000
Bank overdrafts	3,783	**3,783**	3,056	**3,058**
Trade and other payables with NHSE bodies	1,312	**1,312**	7,709	**7,709**
Trade and other payables with other DHSC group bodies	60,113	**60,113**	78,420	**78,422**
Trade and other payables with external bodies	329,913	**329,913**	283,070	**283,070**
Total at 31 March 2023	**395,121**	**395,121**	**372,255**	**372,259**
Non-financial instruments				
NHS deferred income	59	59	-	59
Non-NHS and Other WGA deferred income	834	834	555	834
Social security costs	744	744	770	744
Tax	679	679	635	679
Provisions	-	-	1,542	
Total liabilities (current and non current) as per Statement of Financial Position	**397,437**	**397,437**	**375,757**	**374,575**

The carrying value is considered to be a reasonable proxy for assets and liabilities held at amortised cost.

19. Operating segments

International Financial Reporting Standards (IFRS) require financial performance to be analysed across key decision making segments.

The ICB operates nine segments across nine places all of which commission Health Care Services. As permitted by IFRS 8 information for segments with similar economic characteristics may be presented in aggregate and therefore these segments are included in aggregate below as the commissioning of healthcare services.

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning of Healthcare Services	4,602,120	(31,885)	**4,570,235**	54,076	(397,437)	**(343,361)**
Total	**4,602,120**	**(31,885)**	**4,570,235**	**54,076**	**(397,437)**	**(343,361)**

19.1 Reconciliation between Operating Segments and Statement of Comprehensive Net Expenditure

	31 March 2023 £'000
Total net expenditure reported for operating segments	4,570,235
Reconciling items:	
Finance Expense	33
Total net expenditure per the Statement of Comprehensive Net Expenditure	**4,570,268**

20. Joint arrangements - interests in joint operations

20.1 Interests in joint operations

Name of arrangement	Other parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY 31 March 2023 Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000
Better Care Fund	Cheshire East Council	Pooled budget arrangement for Carers Breaks, Local Authority s256, BCF Home First, Community Equipment and Discharges	-	-	-	28,131
Better Care Fund	Cheshire West & Chester Council	Pooled budget arrangement for Carers Breaks, Local Authority s256, BCF Home First, Community Equipment and Discharges	-	-	-	25,164
Integrated pooled fund for adult continuing healthcare	St Helens Council	Pooled budget arrangement for the provision of care packages for adults who qualify for CHC/FNC, are S117 or joint funded.	2,294	1,691	-	23,166
Better Care Fund	St Helens Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	14,571
Better Care Fund	Sefton Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	22,691
Better Care Fund	Wirral Council	Pooled budget arrangement for the commissioning service for the provision of health and social care.	-	-	-	24,081
Better Care Fund	Halton Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	9,058
Integrated pooled fund for adult continuing healthcare	Halton Council	Pooled budget arrangement for the provision of care packages for adults who qualify for CHC/FNC, are S117 or joint funded.	800	2,680	-	3,696
Better Care Fund	Warrington Borough Council	Pooled budget arrangement for the integration of Health & Social Care	-	-	-	16,646
Better Care Fund	Knowsley Metropolitan Borough Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	1,658
Integrated pooled fund for Mental Health, Community Support Services, Disability Services and Discharge Fund	Knowsley Metropolitan Borough Council	Pooled budget arrangement for the provision of Mental Health Services, Community Support Services, Disability Services and Discharge Fund	1,174	1,174	-	12,477
Better Care Fund	Liverpool City Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	750	59,195
Integrated Community Equipment and Disability Advice Services (ICEDAS)	Liverpool City Council	Pooled budget arrangement for Community equipment	-	-	796	796
			4,268	**5,545**	**1,546**	**260,318**

20. Joint arrangements - interests in joint operations cont'd

Cheshire
Cheshire has two pooled budget arrangements with Cheshire East Council and Cheshire West and Chester Council. Under the arrangements, funds are pooled for Cheshire East Better Care Fund and for Cheshire West and Chester Better Care Fund. The pools are hosted by Cheshire East Council and Cheshire West and Chester Council under section 75 agreements between the ICB and the other party. The agreements require that plans are jointly agreed and that services under the agreements are jointly commissioned. Regular meetings are held to monitor plans and commissioning arrangements. This is a joint arrangement and the ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Knowsley
Knowsley has a pooled budget arrangement with Knowsley Metropolitan Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Adult's Learning Disability, Mental Health, Community Support Services and the Better Care Fund. The Better Care Fund is a plan for the ICB and Local Authority to work closely together, driving integration and improved outcomes for the three core initiatives being Localities, Safe Supported Discharge and Access Knowsley. The pool is hosted by KMBC. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

Liverpool
Liverpool has a pooled budget arrangement with Liverpool City Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the provision of Integrated Community Equipment and Disability Advice Services (ICEDAS) and to operate a pooled budget for the required Better Care Fund arrangements. The Better Care Fund is hosted by Liverpool City Council. The ICEDAS is hosted by the ICB. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Halton
Halton has a pooled budget arrangement with Halton Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the provision of Adult's Learning Disability, Mental Health, Community Support Services and the Better Care Fund. The pool is hosted by Halton Borough Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

St Helens

St Helens has a pooled budget arrangement with St Helens Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the majority of Continuing Health Care and the Better Care Fund. The pool is hosted by St Helens Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

Sefton
Sefton has a pooled budget arrangement with Sefton Metropolitan Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Self Care, Wellbeing and Prevention, Integrated Care at locality level building on Virtual Ward and Care Closer to Home Initiatives and Intermediate Care and Reablement. The pool is hosted by Sefton Metropolitan Borough Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Wirral has a pooled budget arrangement with Wirral Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for health and social care activities. The pool is hosted by Wirral Borough Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

21. Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Sefton CVS (Paul Cummins is also Trustee of Sefton CVS)	332	-	-	-
Allen & Partners (Naomi Rankin is also a GP Partner at Belle Vale Medical Centre)	807	-	-	-
iGPC Primary Care Network (Naomi Rankin is also a Clinical Director and Shareholder of iGPC Primary Care Network)	475	-	-	-
Leeds Teaching Hospitals NHS Trust is considered a related party by virtue of relationships with the Department of Health and Social Care and therefore with the Group	480	-	-	-
NHS Providers is considered a related party by virtue of relationships with the Department of Health and Social Care and therefore with the Group	7	-	-	-

Transactions with the parties above were on the same trading terms as other suppliers and providers.

The Department of Health and Social Care is a related party and the parent body. During the year the ICB has had a significant number of material transactions with entities which the Department is regarded as the parent.

The main parties in the public sector with which the ICB had dealings were:

NHS England
NHS Business Services Authority.
Alder Hey Children's Hospital NHS Foundation Trust
Bridgewater Community Healthcare NHS Foundation Trust
Cheshire and Wirral Partnership NHS Foundation Trust
East Cheshire NHS Trust
Liverpool Heart and Chest Hospital NHS Foundation Trust
Liverpool University Hospital NHS Foundation Trust
Liverpool Women's NHS Foundation Trust
Manchester University NHS Foundation Trust
Mersey Care NHS Foundation Trust
Mid Cheshire Hospitals NHS Foundation Trust
North West Ambulance Service NHS Trust
Southport and Ormskirk Hospital NHS Trust
St Helens and Knowsley Teaching Hospitals NHS Trust
The Clatterbridge Cancer Centre NHS Foundation Trust
The Countess of Chester Hospital NHS Foundation Trust
The Walton Centre NHS Foundation Trust
Warrington and Halton Hospitals NHS Trust
Wirral Community NHS Foundation Trust
Wirral University Teaching Hospital NHS Foundation Trust
Cheshire East Council
Cheshire West and Chester Council
Halton Borough Council
Knowsley Council
Liverpool City Council
Metropolitan Borough Council of Sefton
St Helens Borough Council
Warrington Borough Council
Wirral Council

22. Events after the end of the reporting period

The ICB took responsibility for commissioning Ophthalmic and Dental Services in the Cheshire and Merseyside region with effect from 1 April 2023 and the ICB's spending allocation is increased to fund the anticipated spend. There are no other events after the end of the reporting period which would have a material effect on the financial statements of the ICB.

23. Losses and special payments

	31 March 2023 £'000
Losses and special payments	35

The ICB had one loss during 2022-23 totalling £35k. Note 4.3 provides details of exit packages agreed and paid in the financial year.

24. Financial performance targets

NHS Integrated Care Board's have a number of financial duties under the NHS Act 2006 (as amended).
NHS ICB performance against those duties was as follows:

	31 March 2023 Target £'000	31 March 2023 Performance £'000
Expenditure not to exceed income	4,614,900	4,602,154
Capital resource use does not exceed the amount specified in Directions	550	543
Revenue resource use does not exceed the amount specified in Directions	4,583,014	4,570,268
Revenue administration resource use does not exceed the amount specified in Directions	42,220	41,350

25. Shortened Accounting period

The ICB came into existence on 1 July 2023 and these accounts are for a nine month period. Comparative figures are presented in the Statement of Financial Position and the related notes and these are the assets and liabilities that were transferred from predecessor organisations. Because of time timing in the year, these items are not directly comparable.

Appendix 1 – Board and Committee Membership and Attendance

NHS Cheshire and Merseyside Board

Member names and attendance

Name	Position	Attendance (eligible to attend)
Raj Jain (Chair)	NHS Cheshire and Merseyside Chair	8 (8)
Graham Urwin	Chief Executive	8 (8)
Tony Foy	Non-Executive Director	8 (8)
Erica Morriss	Non-Executive Director	6 (8)
Neil Large MBE	Non-Executive Director	7 (8)
Hilary Garratt	Non-Executive Director	2 (2)
Professor Steven Broomhead MBE	Partner Member, Local Authority	8 (8)
Councillor Paul Cummins	Partner Member, Local Authority	5 (8)
Ann Marr OBE	Partner Member, provider trust	7 (8)
Professor Joe Rafferty CBE	Partner Member, provider trust	6 (8)
Adam Irvine	Partner Member, Primary Medical Services	7 (8)
Dr Naomi Rankin	Partner Member, Primary Medical Services	2 (2)
Claire Wilson	Director of Finance	8 (8)
Professor Rowan Pritchard-Jones	Medical Director	6 (8)
Christine Douglas MBE	Director of Nursing and Care	7 (7)
Marie Boles	Interim Director of Nursing and Care	1 (1)

The quorum for meetings of the Board will be a majority of members (8) including: The Chair and Chief Executive (or designated deputies), at least one Executive Director, at least one Non-Executive Director, at least one Partner Member and at least one member who has a clinical background or qualification.

Audit Committee

Member names and attendance

Name	Position	Attendance (eligible to attend)
Neil Large MBE (Chair)	Non-Executive Director	3 (3)
Tony Foy	Non-Executive Director	3 (3)
Erica Morriss	Non-Executive Director	1 (3)
Hilary Garratt	Non-Executive Director	0 (1)

For a meeting to be quorate, a minimum of two Non-Executive members of the Board are required, including the Chair or Vice Chair of the Committee.

Remuneration Committee

Member names and attendance

Name	Position	Attendance (eligible to attend)
Tony Foy (Chair)	Non-Executive Director	5 (5)
Erica Morriss	Non-Executive Director	3 (5)
Neil Large MBE	Non-Executive Director	5 (5)
Hilary Garratt	Non-Executive Director	0 (1)
Raj Jain	NHS Cheshire and Merseyside Chair (standing invite)	5 (5)

For a meeting to be quorate, a minimum of two of the Non-Executive members of the Board is required, including the Chair or the Vice Chair.

Finance, Investment and Our Resources Committee

Member names and attendance

Name	Position	Attendance (eligible to attend)
Erica Morriss (Chair)	Non-Executive Director	5 (5)
Tony Foy	Non-Executive Director	3 (5)
Neil Large MBE	Non-Executive Director	5 (5)
Claire Wilson	Director of Finance	5 (5)
Christine Douglas	Director of Nursing and Care	2 (5)*
Christine Samosa	Director of People	3 (5)*
Anthony Middleton	Director of Performance and Planning	2 (5)
Attendance by Alex Mitchell, Alan Howgate and Mark Wilkinson	Associate Director of 'Place' Finance representative	5 (5)*
Adam Irvine	Partner Member, Primary Medical Services	4 (5)
Jane Tomkinson	Partner CEO from at least one of each of the Cheshire and Merseyside provider collaboratives	3 (5)*
Rob Collins	Integrated Care System Provider Finance Director	4 (5)

*Representation from deputies provided

For a meeting to be quorate, at least 50% of the membership must be present (six). This should include two NHS Cheshire and Merseyside Executives, one Non-Executive member of the Board and one Partner Member.

Quality and Performance Committee

Member names and attendance

Name	Position	Attendance (eligible to attend)
Tony Foy (Chair)	Non-Executive Director	8 (8)
Erica Morriss	Non-Executive Director	4 (8)
Christine Douglas MBE	Director of Nursing and Care	7 (7)
Marie Boles	Interim Director of Nursing and Care	1 (1)
Professor Rowan Pritchard-Jones	Medical Director	6 (8)*
Anthony Middleton	Director of Planning and Performance	7 (8)
Paul Mavers / Sarah Thwaites	Healthwatch	2 (8)
Councillor Paul Cummins	Partner Member, Local Authority	6 (8)

*Representation from deputies provided

For a meeting to be quorate, there must be one Non-Executive member of the Board present, including one other Non-Executive member of the Board or Partner Member and either the Medical Director or Director of Nursing and Care.

System Primary Care Committee

Member names and attendance

Name	Position	Attendance (eligible to attend)
Erica Morriss (Chair)	Non-Executive Director	6 (6)
Tony Foy	Non-Executive Director	3 (6)
Neil Large	Non-Executive Director	2 (6)
Adam Irvine	Partner Member, Primary Medical Services	4 (6)
Dr Rob Barnett	Primary Care Professional Group representative – primary medical care	4 (6)

Clare Watson	Assistant Chief Executive	6 (6)
Chris Leese	Associate Director of Primary Care	6 (6)
Christine Douglas MBE	Director of Nursing and Care	2 (6)
Claire Wilson	Director of Finance	6 (6)*
Professor Rowan Pritchard-Jones	Medical Director	6 (6)*
Anthony Leo Deborah Butcher	Place Directors	4 (6) 2 (6)

*Representation from deputies provided.

For a meeting to be quorate, there must be at least five committee members present including, at least one Non-Executive member of the Board or Partner Member, at least one clinical member and at least two NHS Cheshire and Merseyside Directors.

Transformation Committee

Member names and attendance

Name	Position	Attendance (eligible to attend)
Clare Watson (Chair)	Assistant Chief Executive	3 (3)
Tony Foy	Non-Executive Director	1 (3)
Neil Large	Non-Executive Director	2 (3)
Christine Douglas MBE	Director of Nursing and Care	3 (3)*
Fiona Lemmens	Associate Medical Director	3 (3)
Carl Marsh Jan Ledward	Place Directors	2 (3) 1 (3)
Professor Ian Ashworth	Local authority representative (public health)	2 (3)
Hilary Brooks	Local authority representative DASS	1 (3)
Sue Forster	Consultant in Population Health	1 (3)

Tony Mayer Linda Buckley	Provider Collaborative representatives	2 (3) 3 (3)

*Representation from deputies provided

For a meeting to be quorate, there must be at least five committee members present including, at least one Non-Executive member of the Board or Partner Member, at least one clinical member and at least two NHS Cheshire and Merseyside Directors.

Health Care Partnership

Member names and attendance

Name	Position	Attendance (eligible to attend)
Councillor Louise Gittins (Chair)	Local Authority Political Leader	3 (3)
Raj Jain	NHS Cheshire and Merseyside Chair	3 (3)
Graham Urwin	NHS Cheshire and Merseyside Chief Executive	3 (3)
Clare Watson	Assistant Chief Executive	3 (3)
Claire Wilson	Director of Finance	2 (3)
Councillor Christine Bannon Councillor Marlene Quinn Councillor Paul Warburton Councillor Yvonne Nolan Councillor Ian Moncur Councillor Jane Corbett Councillor Sam Corcoran Councillor Marie Wright	Political representation x 9 (including Chair)	3 (3) 3 (3) 2 (3) 1 (3) 3 (3) 3 (3) 1 (3) 1 (3)
Frazer Lake Margaret Jones Marie Wright Carly Brown Anne Marie Lubanski Steven Park	Local Authority Executives x 2	1 (3) 2 (3) 1 (3) 3 (3) 2 (3) 1 (3)

Stephen Watson		1 (3)
Professor Ian Ashworth Margaret Jones	Directors of Public Health x 2	3 (3) 1 (3)
Darren Mochrie	North West Ambulance Service	3 (3)*
Gareth Lee	Cheshire Police	3 (3)
Jonathan Roy	Merseyside Police	2 (3)
Alex Waller	Cheshire Fire and Rescue	3 (3)*
Phil Garrigan	Merseyside Fire and Rescue	2 (3)
Alison Cullen	Voluntary, Community and Faith Sector (Cheshire)	3 (3)
Racheal Jones	Voluntary, Community and Faith Sector (Merseyside)	1 (3)
Peter Broxton	Local Enterprise Partnership (Cheshire)	1 (3)
Adam Irvine	Primary care x 2	2 (3)
Dame Jo Williams Isla Wilson	Provider Collaborative (CMAST, MHLDSC) x 2	3 (3) 3 (3)
Paul Warburton	Housing	2 (3)
Louise Barry Paul Mavers Sarah Thwaites Karen Prior	Healthwatch x 2	2 (3) 1 (3) 3 (3) 1 (3)
Professor Tom Walley Angela Simpson	Higher Education / University x 2	1 (3) 2 (3)

*Representation from deputies provided

For the Health and Care Partnership to be quorate, there must be 50% of the membership present.

Appendix 2 – NHS Oversight Framework - Organisational Detail

Key: Rank banding	
	Highest performing quartile
	Interquartile range
	Lowest performing quartile

NHS OF Metric Name Full	Aggregation source	Period	NHS Cheshire and Merseyside ICB (QYG)
S001a: Number of general practice appointments per 10,000 weighted patients	ICB	2023 03	1,277.76 per 10,000
S007a: Total elective activity undertaken compared with 2019-20 baseline	ICB	2023 01	101.1%
S007b: Elective Activity: Completed pathway elective activity growth	ICB	2023 03	105.7%
S009a: Total patients waiting more than 52 weeks to start consultant led treatment	Provider	2023 04	19,106
	Sub ICB	2023 04	19,771
S009b: Total patients waiting more than 78 weeks to start consultant led treatment	Provider	2023 04	232
	Sub ICB	2023 04	377
S009c: Total patients waiting more than 104 weeks to start consultant led treatment	Provider	2023 04	6
	Sub ICB	2023 04	9
S010a: Total patients treated for cancer compared with the same point in 2019-20	ICB	2023 03	111.8%
S011a: Cancer - percentage of patients on the waiting list who have been waiting more than 62 days	Provider	W/e 04/06/23	12.7%
S012a: Proportion of patients meeting the faster cancer diagnosis standard	ICB	2023 04	67%
	Provider	2023 03	108.6%

NHS OF Metric Name Full	Aggregation source	Period	NHS Cheshire and Merseyside ICB (QYG)
S013a: Diagnostic activity levels: Imaging	Sub ICB	2023 03	107.2
S013b: Diagnostic activity levels: Physiological Measurement	Provider	2023 03	82.7%
	Sub ICB	2023 03	84.3%
S013c: Diagnostic activity levels: Endoscopy	Provider	2023 03	96.1%
	Sub ICB	2023 03	97.3%
S013d: Diagnostic activity levels: Total	Provider	2023 03	105%
	Sub ICB	2023 03	104.1%
S022a: Stillbirths per 1,000 total births	ICB	2021	3.26 per 1,000
S029a: Inpatients with a learning disability and/or autism per million head of population	ICB	2022-23 Q4	49 per 1,000,000
S030a: Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check	ICB	2022-23 Q4	78%
S031a: Rate of personalised care interventions	ICB	2022-23 Q4	104.7 per 1,000
S032a: Personal health budgets	ICB	2022-23 Q3	2.5 per 1,000
S037a: Percentage of patients describing their overall experience of making a GP appointment as good	ICB	2022	55%
S040a: Methicillin resistant staphylococcus aureus (MRSA) bacteraemia infection rate	Provider	2023 04	12
	Sub ICB	2023 04	34
S041a: Clostridium difficile infection rate	Provider	2023 04	144.4%
	Sub ICB	2023 04	124.9%

NHS OF Metric Name Full	Aggregation source	Period	NHS Cheshire and Merseyside ICB (QYG)
S042a: E. coli bloodstream infection rate	Provider	2023 04	141.7%
	Sub ICB	2023 04	125%
S044a: Antimicrobial resistance: total prescribing of antibiotics in primary care	Sub ICB	Apr 2022 - Mar 2023	109.3%
S044b: Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Sub ICB	Apr 2022 - Mar 2023	7.35%
S046a: Population vaccination coverage: MMR for two doses (5-year-olds)	ICB	2022-23 Q3	86.9%
S047a: Proportion of people over 65 receiving a seasonal flu vaccination	Sub ICB	2023 02	80%
S050a: Cervical screening coverage: % females aged 25 to 64 attending screening within the target period	Sub ICB	2022-23 Q3	69.8%
S051a: Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled	ICB	2022-23 Q4	29.5%
S053a: % of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy	Sub ICB	2021-22	89.6%
S053b: % of hypertension patients who are treated to target as per NICE guidance	Sub ICB	2021-22	58.2%
S053c: % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	Sub ICB	2022-23 Q3	59%
S055a: Number GP referrals to NHS Digital weight management service per 100,000 of population	Sub ICB	2022-23 Q4	59.6 per 100,000

NHS OF Metric Name Full	Aggregation source	Period	NHS Cheshire and Merseyside ICB (QYG)
S060a: Aggregate score for NHS staff survey questions that measure perception of leadership culture	ICB	2022	6.97/10
S063a: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	ICB	2022	10.1%
S063b: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	ICB	2022	17%
S063c: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	ICB	2022	24.9%
S067a: Leaver rate	ICB	2023 03	7.96%
S068a: Sickness absence rate	ICB	2023 01	6.13%
S069a: Staff survey engagement theme score	ICB	2022	6.85/10
S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression /promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	ICB	2022	57.6%
S074a: FTE doctors in general practice per 10,000 weighted patients	ICB	2023 04	5.99 per 10,000
S075a: Direct patient care staff in GP practices and PCNs per 10,000 weighted patients	ICB	2022-23 Q3	5.26 per 10,000
S081a: Access rate for IAPT services	ICB	2023 03	64.9%

NHS OF Metric Name Full	Aggregation source	Period	NHS Cheshire and Merseyside ICB (QYG)
S084a: Number of children and young people accessing mental health services as a % LTP indicative trajectory	ICB	2023 03	82%
S085a: People with severe mental illness receiving a full annual physical health check and follow-up interventions as a % of LTP indicative trajectory	ICB	2023 03	82.7%
S086a: Inappropriate adult acute mental health placement out of area placement bed days	ICB	Jan 2023 - Mar 2023	1,885
S101a: Outpatient follow-up activity levels compared with 2019-20 baseline	ICB	2023 03	114.5%
S104a: Neonatal deaths per 1,000 live births	ICB	2021	2.07 per 1,000
S106a: Available virtual ward capacity per 100,000 head of population	ICB	2023 04	14.3 per 100,000
S107a: Percentage of two-hour Urgent Community Response referrals where care was provided within two hours	ICB	2023 03	78.7%
S108a: Number of completed referrals to Community Pharmacist Consultation Service (CPCS) from a general practice per 100,000 population	ICB	2023 02	80.3 per 100,000
S108b: Number of completed referrals to Community Pharmacist Consultation Service (CPCS) from NHS111 per 100,000 population	ICB	2023 02	152.3 per 100,000
S109a: Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	ICB	2023 05	75.4%
S110a: Access rates to community mental health services for adults and older adults with severe mental illness	ICB	2023 03	80.7%

NHS OF Metric Name Full	Aggregation source	Period	NHS Cheshire and Merseyside ICB (QYG)
S115a: Proportion of diabetes patients that have received all eight diabetes care processes	ICB	2021-22 Q4	36.8%
S116a: Proportion of adult inpatient settings offering tobacco dependence services	ICB	2023 03	21.4%
S116b: Proportion of maternity settings offering tobacco dependence services	ICB	2023 03	11.1%
S117a: Proportion of patients who have a first consultation in a post-COVID19 service within six weeks of referral	Provider	2023 03	75.5%
S121a: NHS Staff Survey compassionate culture people promise element sub-score	ICB	2022	7.08/10
S121b: NHS Staff Survey raising concerns people promise element sub-score	ICB	2022	6.62/10
S123a: Adult general and acute type 1 bed occupancy (adjusted for void beds)	Provider	2023 05	95.3%
S124a: Percentage of beds occupied by patients who no longer meet the criteria to reside	Provider	2023 05	19.7%
S125a: Older acute LoS over 60 days % of total discharges	MH Provider	2023 02	25%
S125b: Older acute LoS over 90 days % of total discharges	MH Provider	2023 03	43.6%