Thursday 27 October 2022
10:00am to 12:30pm
The Sports Hall, Crewe Lifestyle Centre, Everybody Health and Leisure, Moss Square, Crewe CW1 2BB

NHS Cheshire and Merseyside

Meeting of the Integrated Care Board

Agenda

Chair: Raj Jain

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
10:00am	**Preliminary Business**			
ICB/10/22/01	Welcome, Introductions and Apologies	Chair	Verbal	-
ICB/10/22/02	Declarations of Interest *(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published in the Board Member Register of Interests)*	Chair	Verbal	-
ICB/10/22/03	Minutes of the previous meeting: • 29 September 2022.	Chair	Paper Approval	*Page 3*
ICB/10/22/04	Board Action and Decision Logs	Chair	Paper For note	*Page 21*
10:10am	**Standing Items**			
ICB/10/22/05	Report of the Chief Executive	GU	Paper For note	*Page 24*
ICB/10/22/06 **10:20am**	Welcome to Cheshire East	MW / LOD	Paper & Presentation For note	*Page 47*
ICB/10/22/07 **10:30am**	Resident Story	MW	Presentation For note	
10:35am	**ICB Key Update Reports**			
ICB/10/22/08 **10:45am**	Cheshire & Merseyside System Month 6 Finance Report	CWi	Paper For approval	*Page 64*
ICB/10/22/09 **10:55am**	Cheshire & Merseyside ICB Quality and Performance Report	AM / CD	Paper For noting	*Page 83*
ICB/10/22/10 **11:10am**	Executive Director of Nursing & Care Report	CD	Paper For noting	*Page 105*
11:20am	**ICB Business Items**			
ICB/10/22/11	Continuous Glucose Monitoring	RPJ	Paper For approval	*Page 111*
ICB/10/22/12 **11:30am**	Provider Collaborative Update	JR	Presentation For note	*Page 120*
ICB/10/22/13 **11:40am**	System Finance Assurance Report	CWi	Paper For noting	*Page 129*
ICB/10/22/14 **11:55am**	Winter Planning 2022-2023	AM	Paper For noting	*Page 135*
12:10pm	**Sub-Committee Reports**			
ICB/10/22/15	Report of the Chair of the Cheshire & Merseyside ICB Remuneration Committee	TF	Paper For approval	*Page 145*

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
ICB/10/22/16	Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Commitee	TF	Paper For noting	*Page 162*
ICB/10/22/17	Report of the Cheshire & Merseyside Chair of the ICB Transformation Committee	CWa	Paper For approval	*Page 173*
12:20pm	**Other Formal Business**			
ICB/10/22/18	Responses to questions raised by Members of the Public in relation to items on the agenda	Chair	For noting	-
ICB/10/22/19	Closing remarks, review of the meeting and communications from it	Chair	Verbal For Agreement	- -
12:30pm	**CLOSE OF MEETING**			

Date and time of next meeting:
28 November 2022
Warrington Conference Centre, Halliwell Jones Stadium, Mike Gregory Way, Warrington, WA2 7NE

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

Speakers

AH	Anthony Middleton, Director of Performance and Planning, C&M ICB
AM	Ann Marr OBE, Partner Member, C&M ICB
CD	Christine Douglas MBE, Director of Nursing and Care, C&M ICB
Cwa	Clare Watso, Assistant Chief Executive, C&M ICB
CWi	Claire Wilson, Executive Director of Finance, C&M ICB
EM	Erica Morriss, Non-Executive Director, C&M ICB
GU	Graham Urwin, Chief Executive, C&M ICB
JR	Joe Rafferty, Partner Member, C&M ICB
LOD	Lorraine O'Donnell, Chief Executive, Cheshire East Council
MW	Mark Wilkinson, Cheshire Place Director, C&M ICB
RPJ	Rowan Pritchard-Jones, Medical Director, C&M ICB
TF	Tony Foy, Non-Executive Director, C&M ICB

Meeting Quoracy arrangements:
Quorum for meetings of the Board will be a majority of members (eight), including:
- the Chair and Chief Executive *(or their nominated Deputies)*
- at least one Executive Director *(in addition to the Chief Executive)*
- at least one Non-Exective Director
- at least one Partner Member; and
- at least one member who has a clinical qualification or background.

NHS
Cheshire and Merseyside

Cheshire & Merseyside Integrated Care Board Meeting

29 September 2022

UNCONFIRMED Draft Minutes

ATTENDANCE		
Name	**Initials**	**Role**
Raj Jain	RJA	Chair, Cheshire & Merseyside ICB ***(voting member)***
Steven Broomhead	SBR	Partner Member, Chief Executive, Warrington Borough Council ***(voting member)***
Christine Douglas	CDO	Director of Nursing and Care, Cheshire & Merseyside ICB ***(voting member)***
Tony Foy	TFO	Non-Executive Director, Cheshire & Merseyside ICB ***(voting member)***
Adam Irvine	AIR	Partner Member, Chief Executive Officer, Community Pharmacy Cheshire & Wirral (CPCW) ***(voting member)***
Dr Fiona Lemmens	FLE	Regular Participant, Associate Medical Director, Cheshire & Merseyside ICB
Anthony Middleton	AMI	Regular Participant, Director of Performance and Improvement, Cheshire & Merseyside ICB
Erica Morriss	EMO	Non-Executive Director, Cheshire & Merseyside ICB ***(voting member)***
Neil Large	NLA	Non-Executive Director, Cheshire & Merseyside ICB ***(voting member)***
Ann Marr	AMA	Partner Member, Chief Executive, St Helens & Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital Trust ***(voting member)***
Dianne Blair	DBL	Regular Participant, Healthwatch Sefton
Chris Samosa	CSA	Regular Participant, Director of People, Cheshire & Merseyside ICB
Graham Urwin	GUR	Chief Executive, Cheshire & Merseyside ICB ***(voting member)***
Clare Watson	CWA	Regular Participant, Assistant Chief Executive, Cheshire & Merseyside ICB
Claire Wilson	CWI	Chief Finance Officer, Cheshire & Merseyside ICB ***(voting member)***
Warren Escadale	WES	Regular Participant (nominated deputy), Voluntary Sector North West (VSNW)
Ian Ashworth	IAS	Regular Participant, CWAC Director of Public Health, , ChaMPs representative
In attendance		

Name	Initials	Role
Diane Blair	DBA	Chief Executive, Healthwatch Sefton
Angela White	AWH	Chief Executive, Sefton CVS
Colin Scales	CSV	*(for item ICB/9/22/11 only),* Chief Executive Officer, Bridgewater NHS FT
Andrew Bibby	ABI	*(for item ICB/9/22/08 only),* Regional Director of Health & Justice and Specialised Commissioning (North West) NHS England – North West Region
Debbie Fairclough	DFA	Minute taker

Apologies

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

Item	Discussion, Outcomes and Action Points	Action by
ICB/9/22/01	**Welcome, Introductions and Apologies:** Raj Jain (RJA), the Chair, introduced himself and informed those present that no fire alarm was expected and outlined the housekeeping rules in the event of an alarm. RJA welcomed the members of the public present at this meeting of the Integrated Care Board (ICB) for Cheshire and Merseyside. Thanks were expressed to Sefton for hosting the meeting today. Apologies were noted in respect of Joe Rafferty and Professor Rowan Pritchard-Jones. All members introduced themselves. RJA reminded those present that this is a meeting held in public and confirmed that some public questions have been received in advance of the meeting. RJA confirmed that some of these questions will be addressed at the end of the meeting and although it will not be possible to address all of them today, all questions will be answered and posted along with the papers on the public website.	
ICB/9/22/02	**Declarations of Interest:** SBR submitted a note to the meeting administrator, DFA at the end of the meeting advising that here was a conflict requiring declaration	

	which had not been apparent at the outset of the meeting as it was not detailed on the agenda. The interest related to his role as a member of the Board of the University of Chester. This was raised incidentally at item ICB/9/22/11 during which a Board public health representative proposed that the people board and its associated workplan could potentially work with organisations such as (as an example only) Chester University.	
ICB/9/22/03	**Minutes and matters of the last meeting held on 4th August 2022:** No amendments or corrections were received in respect of the minutes of the ICB meeting held on 4th August 2022 and these were therefore approved as an accurate record of the meeting. AMA did however wish to make a formal comment on item ICB/8/22/12 relating the establishment of a North Mersey comprehensive stroke centre for hyper-acute services unit (HASU). Thanks and praise were extended to Fiona Lemmens and James Sumner at LUFTH for their support and facilitation for the programme that enabled the successful establishment to take place on 19 September 2022.	
ICB/9/22/04	**Board Actions and Decision Logs:** A copy of the action and decision logs were provided to the Board prior to the meeting and RJA noted that there were no actions pertinent to this meeting's agenda and there were no outstanding actions requiring further update for this meeting. RJA provided an introduction to the remaining items of the agenda noting that this was an incredibly full agenda and the meeting pack was significant. Papers had been shared with members in advance and published on the relevant websites. Those presenting were encouraged to be succinct and draw the key pertinent points to the attention of board members and respect timings on the agenda.	
ICB/9/22/05	**Report of the Chief Executive:** GUR advised that report of the Chief Executive is to provide a mechanism to report on very important issues requiring attention and also include items that are not necessarily substantive items already covered on the agenda. There were three items of particular note, two of which required a decision from members and the other related to the dealing of the annual report and accounts of the first quarter of 2022/23 during which the predecessor CCGs were the statutory bodies. Referring to the annual reports and accounts members were advised that there would not be the usual annual general meetings (AGMs). Ordinarily, the CCG would be required to hold an AGM at which the annual report is presented, within the 6-month period of	

	last day of reporting period. However, as 2022/23 is a year of transition, guidance from NHS England had stated that in order to discharge this duty that the ICB can present the CCG Annual report(s) and Accounts at a public board meeting in lieu of a CCG AGM. GUR advised that the annual report and accounts of all predecessor CCGs will be published on the Cheshire and Merseyside ICB website therefore discharging the duty required of the ICB. Referring to the development of the delegation arrangements that will evolve over time for each of the respective places, the Board were asked to note the work in Sefton to develop a memorandum of understanding for how partners at place will work collaboratively to deliver place priorities and objectives. It was noted that the there is more work to do at ICB level to consider what the final models of governance and delegation may be at place which may vary in form depending on the state of readiness, but that the MOU developed by Sefton was exemplary best practice in providing a firm footing for the arrangements as they develop. The Board was asked to delegate authority to the CEO or the Assistant CEO to sign off such agreements as they emerge however, in cases where it requires the formal signed off of pooled budgets and section 75 agreements, then as matters reserved to the Board they would be brought to a public meeting for approval. The third item GUR wished to highlight was that of the announced budget and the requirements of the NHS which are easily summarised as the ABCDD priorities we are required to implement. Ambulance, backlogs, care, doctors and dentistry. Ambulance service response times must be improved and members and the public were reminded that the patient that is at greatest risk is the patient that the NHS has not yet seen. Whilst noting that 45% of all ambulance delays in in just 17 places that did not include Cheshire and Merseyside, improvements are essential. Backlogs must be addressed as part of the restoration of elective services and to improve services overall. An extra £500m will be made available with a notable focus on supporting early discharge which is very much welcomed but how the money will flow and where the accountability will lie. However, regardless it will be for the NHS and local authorities work together to optimise the care for patients and an agreed plan needs to be developed for winter. In respect of doctors, it is nationally understood that there are significant variations in respect of the provision of primary care (general medical services) and improvements need to be done in a	

	transformational way. Plans will be submitted to the Board in October or November. In 2012 the commissioning of dentistry was reserved to NHS England and did not transfer to CCGs. ICB will become responsible from 1st April 2023 and a strategy needs to be developed now but the Board need to note now the scale of the challenge and the issues that the Board will be required to address. SBR noted that behind the announcements there are incredibly complex and challenged systems particularly those relating to adult social care and delayed discharges and encouraged ongoing partnership working. GUR offered assurances that regardless of how that money flows from Government, its allocation will be decided with LA partners and there is a meeting of GUR and the 9 local authority directors of adult social care on Monday 3 October 2022. **Resolution: The Board:** • noted the contents of the report • approved entering into the Sefton Partnership Board Collaboration Agreement • delegated authority to the Chief Executive and the Assistant Chief Executive to sign off collaboration agreements or memorandum of understanding from other places noting that any arrangements requiring S75 or pooled budget agreements would be submitted to the ICB board approval.	
ICB/9/22/07	**Report of the Place Director – Sefton** RJA invited the Place Director – Sefton to present an overview of Sefton, the priorities, challenges and the work to date. DBU delivered the Sefton Place presentation. Members and the public heard about the key factors impacting on the health and wellbeing of the population of Sefton in respect of health, education, housing, cost of living, access to services, lifestyle choices, age profile, mental health, long term conditions, child health and a range of other factors that are being targeting by the health and wellbeing strategy. DBU described the integration journey between health social care over the past few years and discussed the way partners were continuing to work together to truly collaborate and respond to the population challenges. There is a single vision of having a confident and connected borough that offers the things we all need to start, live and age well, where everyone has a fair change of a positive healthier future. This is underpinned by ten ambitions across the live course of start well, live well, age well and all age. To	

	demonstrate that commitment the partners including the ICB have all signed up to a collaboration agreement that has been approved by the Board today. No further comments or questions were raised and the Board expressed thanks again to Deborah Butcher for the presentation. **Outcome:** The Board noted the report of the Place Director Sefton.	
ICB/9/22/07	**Resident story** DBU introduced a video showing one of the service users in Sefton, David who shared his story of his experienced of the Crisis Cafe The Crisis Cafes have been set up in Southport and Crosby, offering out of hours support to anyone experiencing a mental health crisis. They give adults in Sefton a safe place to go as an alternative to A&E, and demonstrate the huge benefits for our communities, that working in partnership can achieve. Over £500k of funding has been secured to deliver the Crisis Café service over three years and it is estimated that the service has vastly reduced hospital admissions for mental health crises for 90% of the service users they have supported. Since the launch of the service in July 2021 the Crisis Cafes have supported 190 people through over 2,000 in-person or telephone support session and the impact on those attending the Crisis Cafes has been life changing. RJA thanked DBU for sharing the resident story and asked that formal thanks be passed on to David for allowing Board members and the public to hear his story.	
ICB/9/22/08	**Liverpool University Hospitals NHS Foundation Trust Clinical Service Reconfiguration Proposal** RJA invited FLE to present the report with support from Andrew Bibby Director of Specialised Commissioning which is function of NHS England. FLE referred to the report that provided the background and the strategic context of the proposals that had been in development for a number of years and prior to the establishment of the ICBs. Liverpool University Hospitals NHS Foundation Trust (LUHFT) has developed proposals to change the way five services are delivered. Since the merger of the Royal Liverpool and Broadgreen Hospitals NHS Trust and Aintree University Hospital NHS Foundation Trust in 2019, the new Trust (LUHFT) has undertaken a clinical integration	

	programme, the rationale for which is to create single clinical teams for all trust specialties, to establish best-practice clinical models of care, and to locate services in the right place across the Trust's three sites. This model is intended to make the best use of specialist skills, resources and equipment, and to utilise its three sites in the most effective way, both for patients and staff. The services within the scope of this proposal are breast surgery, general surgery, nephrology, urology, and vascular care. The majority of these services are commissioned by NHS Cheshire and Merseyside Integrated Care Board (ICB) with some elements of four of the five services commissioned by NHS England (NHSE) Specialised Commissioning. Both NHS Cheshire and Merseyside ICB and NHSE Specialised Commissioning, are required to approve this proposal, in line with their statutory responsibilities. FLE in particular wished to focus on four key areas for the Board today which are governance, changes to the original proposals, the ICB's public sector equality duty (PSED)/public consultation and the wider business case its impact on the wider system financial picture. In terms of governance, it was noted that this was an inherited business case that had been subject to the full NHS England business case and assurance processes through the CCGs and respective joint committees as detailed in section five of the paper. Four of the services changes have element of specialised commissioning with the exception of breast services which is why specialised commissioning have been heavily involved in the work. Referring to page 93 of the report and matters relating to general surgery the original proposal was to move all emergency surgery to the Aintree site and specialised elective to the Royal site, however as planning has progressed it has become apparent that there are wider ramifications for providers such as NWAS and neighbouring providers so that element of the work has been paused. At a relevant point in time if new proposals are developed decisions will be required in conjunction with OSCs as to whether those plans would require a new consultation exercise. FLE assured members that full regard has been given to the ICB's PSED and the full equality impact assessment had been included in the pack. The full business case detailed in section six of the report sets out the capital and revenue costs had been agreed internally by LUFT board, noting that those agreements were paid pre-COVID and we are now operating in a different financial climate. FLE assured members that this is a key consideration as part of any ongoing	

	development of proposals and the requirement to restore elective services. ABI joined the discussions and commenced by acknowledging the significant amount of work and support of partners in the Liverpool place and their work with the trust. He further summarised that services for which spec comm had a direct interest and reported that the spec comm leadership were supportive of the proposals noting that must be revenue cost neutral to commissioners. AMA concurred that it is was the correct decision to pause the general surgery proposals when you are moving general and emergency surgery to different sites as some of the cases are time sensitive and there are also issues with patients presenting to the wrong place and need to be transferred. Impacts for neighbouring trusts and ambulance services. AMA also expressed her disappointment that S&O was noted as part of the hub and spoke of the vascular service as they are a part of that. Equitable access remains a significant challenge given the demography and geographies and much more work is done as we design services for the population in trying to eliminate inequalities. FLE advised that one of the considerations leading to the pause of the general surgery proposals related to the impact on StH&K and such impacts will remain under consideration as proposals develop. It was acknowledged clinical and through the public consultation that centralisation of specialist services does lead to better outcomes but that can be at the expense of access and more needs to done to address all challenges. RJA requested that for future updates that there is more detail on how equity of access continues to be considered and resolved. NL expressed his concern about the requirement of the Board to resolve legacy cases from CCGs such as the LUFT proposals and the wider strategic impact that may have. NL asked for assurance that there is clinical buy in and also noted that whilst it may not be an additional cost to commissioners, it comes at a cost to the NHS to reconfigure. NL requested to see this proposal in the context of a wider financial strategy for the trust. GUR advised that through the regulatory regime the trust is in an oversight framework which requires the establishment of a system improvement board (SIB) of which the ICB are a partner. A part of that was an independent review of the financial position of LUFT, the draft outcome of which has been received and will be reported to future meeting of the SIB. A timetable has been set out for the trust to come back with a multi year strategy to achieve financial sustainability and a description of the board assurance arrangements that will be in place. This is expected December.	

	FLE confirmed that the merger and proposals are fully clinically lead and supported. PCU asked for an update on the OSC process and was opposition anticipated to any of the proposals. CHI confirmed that the joint OSC was taking place 30 September and FLE advised that opposition was not expected as OSCs had been fully involved and engaged throughout. TFO commended the quality of the consultation arrangements and resulting outcome report. Travel and transport were two key issues that came out of the consultation and queried how these were going to be addressed. The Board were advised that one way this was being addressed was the retention of outpatient services and this issue will remain a priority of the trust working group established to ensure travel and transport is addressed. **Resolutions: The Board:** **Approved** the proposals for the five LUHFT major service changes, which are contained in a business case (and outlined in Section 4 of this paper) and informed by a formal public consultation. **Noted** the decisions of NHS England against the proposals for the four of the five service areas (vascular, general surgery, nephrology and urology) that are in the scope of NHS England commissioning responsibilities.	
ICB/9/22/09	**Cheshire and Merseyside Acute and Specialist Trust (CMAST) Provider Collaborative** AMA gave presentation on behalf of CMAST which was the collaborative that emerged from the hospital cell that was established during the pandemic. It comprises the 13 acute and specialist trusts in C&M. The presentation described the priorities of CMAST which are aligned to the wider objectives of the C&M ICB. The CMAST priorities are detailed as: • Reducing health inequalities • Improving access to services and health outcomes • Stabilising fragile services • Improving pathways • Supporting the wellbeing of our staff and developing more robust workforce plans • Achieving financial sustainability Each work programme is sponsored by a Chair and has a Chief Executive as the SRO. Place directors are represented on three of the programmes.	

	A number of key deliverables were reported to the Board and these included but were not limited to • Implementation of MRI advanced acceleration technology set to deliver 10% increase in activity • C2Ai risk stratification for elective waiting lists • Sapien health coaching app for "prehabilitation" • 5 CDCs open & 4 CDC will open in next 3 years • 110k tests per year in CDCs • 1 large surgical hub now open • 2 additional elective surgical hubs being opened over the next 3 years • Mutual aid accessing fallow theatre capacity across system • 12 international radiology recruits offered posts • Single Cheshire diagnostics staff bank implementation in progress • MOU for staff to work across different sites • C&M theatre utilisation improved from third quartile to the upper quartile • Focused productivity diagnostic initiatives: • Colonoscopy – 25% increase in monthly activity (2069 – >2500 consistently) • Echo – 15% increase in monthly activity (6179 - >7000 consistently). Members also noted good progress in respect of theatre utilisation and long waits and good progress on other national priorities driving down waiting list and delivering for our patients. However, to sustain progress support is needed on a system wide basis. Significant pressures are continuing to impact on discharge and this is compounded by an unstable domiciliary care market. Members concurred that home care services are stretched nationally and locally and factors such as recruitment and retention, increased cost of living and fuel costs are all having an impact. A transformational and new approach is required to ensure sustainable services. GUR advised that AMI has been asked to develop a working programme in respect of domiciliary care. GUR advised that once the additional funding announced is understood that will go towards supporting that funding. WES advised that the VCF had been involved in a pilot in Halton and Warrington and would like share the findings of that work to inform any other similar programmes. SBR recommended that NHS colleagues connect in with LA colleagues in adult and children social care. **Resolutions: The Board** **Noted** the report and progress to date	

	Noted AMI would be developing a work programme for domiciliary care	
ICB/9/22/10	**Assurance Process for Substantial Change** CW presented the paper and the associated flowcharts and appendices for information and noting. The report outlined that Cheshire and Merseyside Integrated Care Board (ICB) is the organisation with statutory responsibility for ensuring that NHS substantial service change processes comply with legislative requirements, this duty had previously sat with Clinical Commissioning Groups. It was advised that a number of substantial change initiatives are already underway, and a project and programme mapping exercise are taking place which will identify if there are any further initiatives which should be managed through this process. Those schemes already identified across Cheshire and Merseyside which are being managed through the substantial service change process are: • East Cheshire Trust and Stockport Joint Clinical Strategy • Maternity Intrapartum service repatriation following suspension during pandemic at East Cheshire Trust • Configuration of services across Liverpool University NHS Foundation Trust sites • Liverpool Women's Hospital future service development plans • Redesign of Stroke Services in North Mersey • Shaping Care Together Programme focused on Acute Sustainability at Southport and Ormskirk Trust • Eastern Sector Cancer Hub work which focuses on developing services for populations within the Mid Mersey population • Review of Cheshire and Merseyside Commissioning Policies to remove historical differences in access and service provision in predecessor CCGs. AMA commented that the list didn't appear to detail just larger strategic programmes but also included some apparently smaller scale programmes that would not have a large impact. There did not appear to be any consistency to the approach for how programmes are included. CWA advised that the programmes are subject to ongoing review and risk stratification so that a robust approach to prioritisation for determining those that would proceed. The ICB is working with NHS England to ensure arrangements for assessment are robust and also be confident that all programmes have been captured and have been subject to relevant PSED procedures.	

	CWA agreed to provide a further update to the Board in November. **Resolutions: The Board:** • Noted the work undertaken with NHS England, and any programmes identified as meeting the threshold for substantial change, to ensure compliance with national policy and legislation. • Noted that the Transformation Committee will offer an assurance mechanism for the Board. • Noted the "project and programme mapping" exercise underway across the ICB, which will identify any further programmes of work to be managed through this process. • Noted the plan to develop a prioritisation process, including financial framework, by which to ensure our resources are targeted most appropriately in order to deliver the ICP strategy and ICB Five Year Joint Forward Plan.	
ICB/9/22/11	**Update on the Cheshire and Merseyside People Board** CSA and CSCa provided an update on the work of the People Board. The purpose of the Board is to bring together health and care organisations and key stakeholders to provide strategic leadership that ensures the implementation of the People Plan and system wide workforce plans. The Board had emerged from the local workforce action boards which were committees of Health Education England and comprises membership from across the wider system. In 2020 the national People Plan created regional and system people boards whose focus to date has been the allocation of workforce development funding. The ICB Board were pleased to note some of the key achievements of: • Nursing and midwifery workforce programme – including a system approach to Continuous professional development • Development of community health workers • Careers and engagement programme – encouraging youngsters to consider careers in health and social care • Development of new roles in social care through Skills for Care • Primary care nursing development programmes. The workforce priorities for 2022 – 2025 are system wide workforce planning, creating new opportunities, promoting health and wellbeing, maximising and valuing the skills of staff and creating a positive and inclusive culture.	

	AIR – really value this work and really pleased to see wider primary care engagement and would welcome more work on including PCNs. IAS – welcomed the update and the fact that public health included and asked for additional information on how school nurses and health visitors are captured. He also advised that work is underway with places such as the University of Chester that could be connected in. GUR further asked how other educational institutions would be engaged in this working noting that it wouldn't be possible to include them all but would be relevant to have some local connectivity. CSA advised that there are arrangements in place to secure inputs from education. WES – welcome the inclusion of VCF but suggested that it also captured the informal carers cohort. EMO queried the way in which implementation can be assured. CSA confirmed that the governance arrangements are designed to ensure that there is a robust approach to implementation. Board members welcome the report and commended the work of the individuals involved on progress to date and the exemplary approach to partnership working. RJA requested that there is continued work to connect the People Board into the ICB Board in C&M. RJA further requested the provision of high-quality data. **Resolution: The Board** Received the progress update	
ICB/9/22/12	**Developing the Cheshire and Merseyside Integrated Care Partnership (ICP)** **CWA** presented a progress update on the work to date on the development of the Cheshire and Merseyside Integrated Care Partnership that has emerged from the health and care partnership. The ICP is a statutory committee that is formed jointly between the NHS ICB and upper tier local authorities that fall within the ICS area. The ICP is responsible for producing the integrated care strategy, by December 2022 that sets out how it will meet the health and wellbeing needs of the population of the ICS area. The ICP has agreed its work programme and these were detailed in section 2.8 of the report. The Board were advised that a workshop of most founding members that took place on 20 September 2022 Louise Gittins, Leader of Cheshire West and Chester Local Authority was supported unanimously as the designate Chair of the C&M HCP.	

	Those present at the meeting commented positively on the work to date noting the work is built upon the needs of patients and the public and welcomed further future updates. **Resolution: The Board** • Approved the appointment of Louise Gittins as the designate Chair of the ICP • Approved the process for the appointment of a vice chair • Noted the progress in developing the C&M ICP (known locally as Cheshire and Merseyside Health Care Partnership (HCP) • Noted that it will receive a further update at the November Board meeting following the first formal meeting of the C&M HCP in early November.	
ICB/9/22/13	**Cheshire & Merseyside System Month 5 Finance Report** CWI presented the report advising that as at 31 August 2022 (Month 5), the ICS 'System' is reporting an aggregate deficit of £45.1m against a planned deficit of £32m resulting in an adverse year to date variance of £13.1m. In particular CWI drew three key areas to the attention of the Board. Firstly, the forecast requires some significant ambitious improvements to the run rate that included in the plan; Secondly, the plans include challenging cost improvement targets and efficiency assumptions, the plan assumes all CIPS will be delivered 50% of which are non-recurrent efficiencies and thirdly, there is a need to develop a system wide risk report. It was further reported that there is a level of unmitigated risk however these remain under review and there is ongoing engagement with providers to understand how these can be addressed. AMA enquired as to the extent of the credibility and robustness of some of the financial plans noting the significant challenges. CWI responded to say that in her opinion there are some providers for which their plans seem unlikely to be realised as they are some distance from being able to provide adequate assurances. These risks are compounded by winter pressures and other pressures such as cost of fuel. NLA explained that there is a need to understand in a comprehensive way the full picture of the financial position for all organisations across C&M and so that through performance management arrangements, opportunities to support providers can be identified.	

	RJA requested a system wide financial recovery regime be descried and reported to the Board meeting in November. SBR was particularly concerned about the Countess of Chester position and GUR advised that there is service improvement board in place which is co-chaired by the ICB and region and a governance review is currently underway, due to report by the end of October. **Resolution: The Board** Noted the update report	
ICB/9/22/14	**Cheshire & Merseyside ICB Quality and Performance Report** AMI introduced the detailed paper that provided an overview of key metrics drawn taken 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. The report included the letter from Richard Barker, Regional Director (North West) of 23 August to the ICB Chief Executive that set out the areas of the C&M plan that require further attention and work is ongoing to ensure that these are addressed. RJA welcomed the report and noted that the work that is now in progress, iterating the necessity for ongoing provision and utilisation of high-quality data. TFO commented on the work of the quality committee that is focussing on triangulation of data and intelligence, and also looking at data that is included in the reports from the place quality committees and assured that there will be ongoing development of this work so that there is a clear line of sight on all quality related issues. EMO noted the positive action on health and wellbeing of staff and enquired in general about other activities that are taking place to support staff. CSA summarised a number of key schemes designed to further the health and wellbeing of staff. There was concerned expressed by RJA about the percentage of people with a learning disability that had received a health check. TFO confirmed this would be addressed in the quality committee chair update report. **Resolution: The Board** Noted the update report	
ICB/9/22/15	**Executive Director of Nursing and Care Report** The report was presented by CDO that provided assurance from the Executive Director of Nursing & Care to the C&M ICB Board regarding the quality, safety and patient experience of services	

	commissioned and provided across the geographical area of Cheshire & Merseyside. The report set out the progress that the ICB has made regarding quality, safety and patient experience of services commissioned and provided across the geographical area of C&M. It demonstrated the progress made of the arrangements in place for ensuring the fundamental standards of quality are adopted and delivered. There were two important highlights: the publication of the review of 121 Midwifery Service and the Joint Targeted Area Inspection (JTAI) of Cheshire East Safeguarding service. Both reports will be submitted to the Quality and Performance Committee in October during which a review the emergent recommendations and their impact for C&M will take place. The report further described the quality governance arrangements, committees and groups in place across C&M and also set out the additional developing arrangements and how they align to the accountabilities of the ICB. **Resolution: The Board** Noted the update report	
ICB/9/22/16	**Report of the Chair of the ICB Audit Committee** NLA, audit committee Chair presented the detailed report and was in particular pleased to advise that following an audit by MIAA on the closedown arrangements for the CCGs, they were able to offer significant assurances that all actions had been completed effectively. It was recognised that closedown and transfer is a significant and complex task and thanks were extended to those involved for their excellent work in that respect. Other issues that had been subject to a review by the audit committee were conflicts of interest, the approach for annual reports and accounts and information governance policies. **Resolution: The Board** • noted the items covered by the Audit Committee at its first meeting • approved the Committee recommendation to agree the proposed amendments to the Terms of Reference of the ICB Audit Committee • noted the approval of the Internal Audit Plan for the ICB • approved ICB Anti-Bribery and Counter Fraud Policy • noted the approval of the ICB Anti-Fraud Plan • approved the Committee recommendation to appoint an ICB Counter Fraud Champion and the stated named post to undertake this role	

	• approved the ICB Information Governance Policies and statements / Privacy notices and their subsequent publication • noted the future plans regarding Internal and External Audit arrangements for the ICB.	
ICB/9/22/17	**Report of the Chair of the ICB Quality and Performance Committee** TFO, chair of the Quality and Performance Committee presented the report that set out the key areas of business that the committee had been focussed on. Some areas of note were the GP survey results which demonstrated that there are some areas requiring improvement such as, access. The outputs and response to the survey will remain under review. The quality dashboard was also a key area of business. TFO advised that there were two matters he wished to escalate to the Board which related to the annual health checks for individuals with a learning disability – uptake is very low. Although this is typical at this time of years as uptake tends to increase towards the end of the year, this is not satisfactory and places will be asked to support improvements. The second issues relates to the "Nobody is listening - Sickle Cell report. The ICS is required to provide a response to the findings. RJA a progress update from the Q&P committee on LD health checks at future meetings. There was a further requested that RPJ provides a clinical response the Nobody Is Listening report at the November Board. AMA confirmed that members of CMAST will connect with RPJ. **Resolution: The Board** • Noted the content of the report and actions taken • Considered the matters escalated to the ICB Board regarding: • No One is Listening Enquiry • Annual Health Checks for People with Learning Disabilities • Approved the amendments to the revised Terms of Reference for the ICB Quality & Performance Committee.	
ICB/9/22/18	**Report of the Chair of the ICB System Primary Care Committee** EMO, Chair of the System Primary Care Committee presented the report supported by CWA, the executive director responsible for primary care, general medical services. The detail of the business items that had been discussed were summarised in the report but there were two that were of particular note.	

	CWA advised that as the committee meets bi-monthly there may be times when matters requiring urgent attention or decision need to be addressed between meetings. The original proposal had been to have nine primary care committees to make decisions or whether this should be a matter delegated to place directors. A substantive proposal on final arrangements will be submitted to the Board. AIR noted that the representation from Local pharmaceutical services (LPS) had been omitted from the membership on the terms of reference. This is to be amended. **Resolution: The Board** • Noted the contents of the report • Approved amendments to the Committees Terms of Reference subject to membership from LPS being included.	
ICB/9/22/19	**Response to questions raised by the members of the public** RJA advised the Board and members of the public present that questions that had been received before the meeting had been addressed and the responses ware available on the website.	
ICB/9/22/20	**Closing remarks and review of the meeting and communications from it**	
ICB/9/22/21	**Any Other Business:** There was no other business.	

Date of Next Meeting: 27 October 2022

End of Meeting

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2022-23

Updated: 19 October 2022

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
ICB-AC-22-01	01-Jul-2022	**ICB Constitution**	The following changes to the ICB constitution will be made:- 1) The wording for section 3.7.2 will be reviewed and revised subject to the agreement of the Board. 2) The wording for section 3.7.2 will be reviewed and revised subject to the agreement of the Board. 3) The wording of section 7.3 will be reviewed to ensure completeness. 4) The role of the local authority will be strengthened and added to the final version document prior to publication. 5) The principles in section 6.2.1 will be revised and updated subject to the approval of the Board.	Clare Watson	27-Oct-2022	*Amendments will be included as part of any overall proposed amendments for approval that will come to the Board in October following completion of the review of the Constitution, SORD and SFIs and Decision and Functions Map*	COMPLETED
ICB-AC-22-02	01-Jul-2022	**ICB Functions and Decision Map**	The diagram/wording on page 241 will be reviewed to make the link between the ICB and the Health and Wellbeing Boards clearer.	Claire Wilson	27-Oct-2022	*Amendments will be included as part of any overall proposed amendments for approval that will come to the Board in October following completion of the review of the Constitution, SORD and SFIs and Decision and Functions Map*	COMPLETED

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2023

Updated: 19 October 2022

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-01	01-Jul-2022	**ICB Appointments (Executive Board Members)**		The Chair of the ICB, the CEO of the ICB and the Chair of the ICB Audit Committee agreed the following appointments as Executive Members of the Integrated Care Board:- 1) Claire Wilson, Director of Finance; 2) Professor Rowan Pritchard Jones, Medical Director 3) Christine Douglas MBE, Director of Nursing and Care.. They also agreed that Marie Boles, Interim Director of Nursing and Care, will fulfil this position until the substantive postholder commences.	
ICB-DE-22-02	01-Jul-2022	**ICB Appointments (Non-Executive Board Members)**		The Chair of the ICB, the CEO of the ICB and the Chair of the ICB Audit Committee agreed the following appointments as Non-Executive Members of the Integrated Care Board:- Neil Large MBE, Tony Foy and Erica Morriss.	
ICB-DE-22-03	01-Jul-2022	**ICB Appointments (Partner Members)**		The Chair of the ICB, the CEO of the ICB and the Chair of the ICB Audit Committee agreed the following appointments as Partner Members of the Integrated Care Board:- Ann Marr OBE and Dr Joe Rafferty CBE.	
ICB-DE-22-04	01-Jul-2022	**ICB Constitution**		The Integrated Care Board approved:- 1) The NHS Cheshire and Merseyside Constitution subject to some agreed updates (see action plan ref: ICB-AC-22-01 for details). 2) The Standards of Business Conduct of NHS Cheshire and Merseyside. 3) The Draft Public Engagement/Empowerment Framework of NHS Cheshire and Merseyside. 4) The Draft Policy for Public Involvement of NHS Cheshire and Merseyside.	
ICB-DE-22-05	01-Jul-2022	**Scheme of Reservation and Delegation**		The Integrated Care Board approved:- 1) The Scheme of Reservation and Delegation of NHS Cheshire and Merseyside. 2) The Functions and Decisions Map of NHS Cheshire and Merseyside. 3) The Standing Financial Instructions of NHS Cheshire and Merseyside. 4) The Operational Limits of NHS Cheshire and Merseyside.	
ICB-DE-22-06	01-Jul-2022	**ICB Committees**		The Integrated Care Board approved:- 1) The core governance structure for NHS Cheshire and Merseyside. 2) The terms of reference of the ICB's committees. It also noted the following:- i) The proposed approach to the development of Place Primary Care Committee structures which will be subject to further reporting to the Board. ii) The receipt of Place based s75 agreements which govern defined relationships with and between specified local authorities and the ICB in each of the 9 Places.	
ICB-DE-22-07	01-Jul-2022	**ICB Roles**		The Integrated Care Board agreed the lead NHS Cheshire and Merseyside roles and portfolios for named individuals, noting that the Medical Director will be the SIRO and the Executive Director of Nursing and Care will be the Caldicott Guardian.	
ICB-DE-22-08	01-Jul-2022	**ICB Policies Approach and Governance**		The Integrated Care Board:- 1) Noted the contractual HR policies that will transfer to the ICB alongside the transferring staff from former organisations. 2) Endorsed the decision to adopt NHS Cheshire CCG's suit of policies as the ICB policy suite from 1st July 2022. 3) Agreed to establish a task and finish group to set out a proposed policy review process, using the committee structure for policy approval. 4) Noted the intention to develop a single suite of commissioning policies to support an equitable and consistent approach across Cheshire and Merseyside.	
ICB-DE-22-09	01-Jul-2022	**Shadow ICB Finance Committee Minutes Approval**		The Board agreed that the minutes of the Cheshire and Merseyside Shadow ICB Finance Committee held on 30th June 2022 can be submitted to the first meeting of the ICB's established Finance, Investment and Our Resources Committee.	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

add logo

Decision Log 2022 - 2023

Updated: 19 October 2022

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-10	04-Aug-2022	**Cheshire & Merseyside ICB Financial Plan/Budget**		1) The Board supported the financial plan submission made on 20th June 2022 in relation to the 2022/2023 financial year. 2) The Board approved the initial split for budgetary control purposes between 'central ICB' and 'Place' budgets for 2022/23 resulting in a headline 20%/80% split respectively.	
ICB-DE-22-11	04-Aug-2022	**Cheshire & Merseyside System Month 3 (Quarter One) Finance Report**		The Board noted the Month 3 Financial Report.	
ICB-DE-22-12	04-Aug-2022	**Cheshire & Merseyside Month 3 (Quarter One) Performance Report**		The Board noted the Month 3 Performance Report and requested that the next report includes data around mental health indicators and the wider primary care service.	
ICB-DE-22-13	04-Aug-2022	**Establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire**		The Board approved the clinical case for the establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire subject to an ongoing financial review.	
ICB-DE-22-14	04-Aug-2022	**Virtual Wards – update on their expansion across Cheshire and Merseyside**		The Board noted the Virtual Wards update.	
ICB-DE-22-15	04-Aug-2022	**Responses to questions raised by Members of the Public in relation to items on the agenda**		The Board agreed to respond to all public questions raised prior to the August meeting.	
ICB-DE-22-16	29-Sep-2022	**Chief Executive Report**		1) The Board approved entering into the Sefton Partnership Board Collaboration Agreement 2) The Board approved the recommendation to delegate authority to the Chief Executive and the Assistant Chief Executive to sign off collaboration agreements or memorandum of understanding from other places noting that any arrangements requiring S75 or pooled budget agreements would be submitted to the ICB board approval.	
ICB-DE-22-17	29-Sep-2022	**Liverpool University Hospitals NHS Foundation Trust Clinical Service Reconfiguration Proposal**		1) The Board approved the proposals for the five LUHFT major service changes, which are contained in a business case (and outlined in Section 4 of this paper) and informed by a formal public consultation 2) The Board noted the decisions of NHS England against the proposals for the four of the five service areas (vascular, general surgery, nephrology and urology) that are in the scope of NHS England commissioning responsibilities.	
ICB-DE-22-18	29-Sep-2022	**Developing the Cheshire and Merseyside Integrated Care Partnership (ICP)**		1) The Board approved the appointment of Louise Gittins as the designate Chair of the ICP 2) The Board approved the process for the appointment of a vice chair	
ICB-DE-22-19	29-Sep-2022	**Report of the Audit Committee Chair**		1) The Board approved the Committee recommendation to agree the proposed amendments to the Terms of Reference of the ICB Audit Committee 2) The Board approved the Committee recommendation to appoint an ICB Counter Fraud Champion and the stated named post to undertake this role 3) The Board approved ICB Information Governance Policies and statements / Privacy notices and their subsequent publication	
ICB-DE-22-20	29-Sep-2022	**Report of the Chair of the ICB Quality and Performance Committee**		The Board approved the proposed amendments to the revised Terms of Reference for the ICB Quality & Performance Committee	
ICB-DE-22-21	29-Sep-2022	**Report of the Chair of the ICB System Primary Care Committee**		The Board approved the proposed amendments to the Committees Terms of Reference subject to membership from LPS being included.	

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Chief Executives Report

27 October 2022

Agenda Item No	**ICB/10/22/05**
Report author & contact details	Graham Urwin, Chief Executive
Report approved by (sponsoring Director)	-
Responsible Officer to take actions forward	Graham Urwin, Chief Executive

Chief Executives Report (October 2022)

Executive Summary	This report provides a summary of issues not otherwise covered in detail on the Board meeting agenda. This includes updates on: • System Assurance Review with NHS England • Staff Consultation • Community Diagnostic Centres in Cheshire & Merseyside • Launch of the North West Imaging Academy (NWIA) • Specialised Services Update • Autumn 2022 COVID-19 Booster Programme Update • Pledges • NHS Cheshire & Merseyside Citizens Panel development • Freedom to Speak Up Guardian • Commitment to achieve Net Zero • MOU Delegation Agreement with NHSE • Technical Constitution changes • Police and Crime Commissioner Merseyside • LUFHT Update.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X	X			
Recommendation	**The Board is asked to:** • **note** the contents of the report • **approve** the recommended change in the ICBs named Freedom to Speak Up Guardian.				

Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**
	X		X	X
	Legal	**Health Inequalities**	**EDI**	**Sustainability**
	X			X

Management of Conflicts of Interest	No	
Next Steps	Subject to approval from the Board, the ICB website will be updated to reflect the new Freedom to Speak Up Arrangements.	
Appendices	**Appendix A**	Specialised Services Segmentation.
	Appendix B	North West Imaging Academy details

Chief Executives Report (October 2022)

1. Introduction

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

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

2. System Assurance Review with NHS England

2.1 The first System Assurance Review between NHS Cheshire & Merseyside ICB and NHS England North West region is due to take place on the 28 October 2022. This provides an opportunity for the ICB to demonstrate the excellent work we have undertaken since our establishment and provide assurance to NHS England of our plans to address future challenges and meet our strategic objectives and ambitions. As an ICB we have been asked to focus on providing assurance on a number of areas we are responsible for including:

- ICB development
- Quality of care, access and outcomes
- Preventing ill-health and reducing inequalities
- Finance and use of our resources
- Our people
- Wider strategic priorities and operational delivery
- Climate change and sustainability.

2.2 I will provide feedback on how the review went within my report to the Board in November.

3. Staff Consultation

3.1 Consultation with all staff on the proposed structures for the ICB commenced on the 17 October 2022 and will run until the 10 November 2022. The proposed structure will support our nine places in their integration agenda, whilst ensuring that the agenda is clinically led and that quality / quality improvement and learning are key components of the ICB.

3.2 Invariably having nine separate Clinical Commissioning Groups (CCGs) gave rise to things being done differently and moving from nine CCGs to a single ICB has several challenges, however we have been committed all along to giving certainty to our staff who have served the NHS so well and trying to make the transition process as seamless as possible.

3.3 I am pleased to confirm that the structures presented to staff will ensure that there is a post for every substantive employee who transferred in to the ICB on the 1 July 2022 together with those who have joined us as a permanent employee since July 2022.

3.4 We remain committed that the majority of the work that we do will be undertaken in and through the nine Place teams across Cheshire and Merseyside. However, in bringing together the new organisation there are some tasks and functions that are best done once across the ICB so we will be establishing a number of central teams who will work with colleagues in the nine Places.

3.5 Like all public services, we are required to demonstrate that our services provide good value for taxpayers' money and must apply the same scrutiny to the use of agency staff and external /off payroll consultants as our colleagues in provider trusts and we will continue to review such arrangement over the next few weeks .

3.6 Over the next few weeks there will be a number of HR drop-in sessions and opportunities for staff to ask questions of the Directors and the HR team.

4. Community Diagnostic Centres in Cheshire & Merseyside

4.1 Community Diagnostic Centres contribute to six primary aims - improve population health outcomes, increase diagnostic capacity; improve productivity and efficiency; reduce health inequalities; improve patient experience; and support the integration of primary, community and secondary care.

4.2 The roll out of Community Diagnostic Centres across Cheshire and Merseyside continues apace with the announcement that the Government has approved the business cases for two new Community Diagnostics Centres to be established in Cheshire and Merseyside.

4.3 The new sites in Halton (Nightingale Building) and Southport (Southport and Formby District General Hospital) have been selected following analysis to determine where Community Diagnostics Centres would be most beneficial in reducing waiting lists and tackling health inequalities whilst making the best use of existing NHS estates. It is anticipated they will become operational in Quarter Two 2022/23 and will provide up to 55,000 additional tests for Cheshire and Merseyside patients.

4.4 Alongside this, the existing Clatterbridge Diagnostic Centre in Wirral and St Helens Community Diagnostics Centre also successfully accessed additional capital funding to expand their services, namely major imaging tests, endoscopy (at St Helens only) and respiratory tests at both sites.

4.5 Local patients already benefit from the existing five centres across Cheshire and Merseyside, with Community Diagnostics Centres in St Helens, Wirral, Liverpool, Ellesmere Port and Northwich. They expect to have delivered almost 140,000 tests in 2022/23.

4.6 Plans for further provision in Cheshire East and Liverpool are currently under development and we anticipate recommendations being available for consideration in December.

5. Launch of the North West Imaging Academy (NWIA)

5.1 In 2021, following the publication of the Richards Review for Diagnostic Services, a North West team, led by Health Education England (HEE), comprising NHS Trusts, consultant radiologists, radiographers, Trust workforce leads, Universities involved in imaging education and training, imaging and Cancer Alliance workforce leads came together to collaboratively design the model for a new North West Imaging Academy, supported by national funding of £2.8 million.

5.2 The Academy comprises a consortium of delivery providers including NHS Trusts, Universities and the North West School of Radiology (HEE) with the primary aim of enhancing imaging in the region. This is for example facilitating a 20% increase in the number of Doctors entering specialist Radiology training. The model developed by the North West team has been praised by the national diagnostics team as being innovative, ambitious and designed to deliver the ambition of the Richards Review for imaging services.

5.3 The NWIA will be formally launched on the 24 November 2022 at an event to be held at NWIA Training Hub and Radiology Academy @ Edge Hill University Medical School. Further details can be found in Appendix B.

6. Specialised Services Update

6.1 NHS England published the final version of the Pre-Delegation Assessment Framework (PDAF) for Specialised Services on 3 October 2022. The date for submission of the PDAF for Specialised Services remains the 4 November 2022. Whilst the PDAF is largely unchanged from the previous drafts in terms of themes, there is now an opportunity to clarify whether ICBs are aiming for delegation in 2023 or 2024 with different requirements for each. Due to the amount of work and due diligence required as part of the delegation the Director of Finance took the decision to aim to take on the commissioning of specialised services for 2024.

6.2 C&M ICB will also be required to work with neighbouring ICBs to agree how the services not delegated to individual ICBs but collectively commissioned will be governed. We will also be required to jointly work with NHS England during 2023/24 via a Joint Committee to develop our PDAF and be able to take on the full range of delegated services from April 2024. One return for the proposed multi-ICB footprint will be required.

6.3 Attached for reference is the proposed list of services and the footprint upon which they will be commissioned (Appendix A). The PDAF will be shared with Board members for information following submission.

7. Autumn 2022 COVID-19 Booster Programme Update

7.1 The Autumn booster offer is now into its sixth week in Cheshire and Merseyside. As well as the Moderna bivalent vaccine we now have Pfizer bivalent in circulation, with both vaccines covering the original COVID-19 strain as well as the Omicron variant.

7.2 Cheshire & Merseyside are leading the way for the North West in vaccinating our Care home residents and staff with 64% of all homes now visited half way through the programme. Knowsley have completed all of their care home visits closely followed by Wirral and St Helens. This is a fantastic achievement in prioritising and vaccinating this very vulnerable group.

7.3 Between the 5 September and 14 October 2022, the Cheshire and Merseyside programme has delivered over 360,000 seasonal boosters and over 16,000 primary doses as part of the evergreen offer. As of 14 October 2022, the national booking system now enables people aged 50 to book their vaccination and thus opens all the eligible cohorts for this phase.

7.4 We are continuing with commissioning the Living Well service (offered by Cheshire Wirral Partnership) which is a system wide offer, directed by Place to target hard to reach, seldom heard groups to offer the autumn booster and evergreen offer. To date the service has delivered almost 3,000 COVID-19 vaccinations and almost 650 health screenings.

7.5 Initial data on uptake in healthcare workers in Trusts across Cheshire and Merseyside has indicated that over 20,000 COVID-19 vaccinations have been delivered. This is the best uptake in the Northwest to date.

8. Pledges

8.1 The ICB has recently signed the Armed Forces Covenant,[1] which is a pledge to acknowledge and understand the needs of the Armed Forces community in Cheshire and Merseyside. As an organisation we will work with our partners to ensure that no member of the Armed Forces Community should face disadvantage in the provision of public and commercial services compared to any other citizens and that in some circumstances special provision may be justified, especially for those who have given the most, such as the injured or bereaved.

8.2 The ICB has also recently signed the Mencap Treat Me Well Pledge[2], which is pledge to tackle the health and social inequalities faced by people with a learning disability living in the Cheshire and Merseyside area. As an organisation we will work towards achieving the stated commitments within the pledge.

[1] https://www.nhsemployers.org/articles/signing-armed-forces-covenant#:~:text=To%20sign%20the%20covenant%2C%20you%20must%20agree%20to,of%20the%20community%20especially%20the%20injured%20or%20bereaved.
[2] https://secure.mencap.org.uk/en-gb/register-treat-me-well-pledge-pack

9. NHS Cheshire & Merseyside Citizens Panel development

9.1 The first phase of recruitment to NHS Cheshire and Merseyside's Citizens' Panel launched on Monday 17 October 2022. The Citizens' Panel will form part of the wider NHS Cheshire and Merseyside Public Engagement Framework. It will help us develop our approach to working with people and communities and strengthen our ability to demonstrate the impact that people's views, experiences, and insights have on our work. We will consult our panellists on system- wide health and care issues, invite their involvement in decision making, and in helping us to further shape our engagement approach.

9.2 One of the key benefits of a Citizens' Panel is the opportunity to engage with people from all sections of the community, and not simply community activists or people that are already engaged with local organisations. Reducing health inequalities across Cheshire and Merseyside is a key objective, and it is therefore important that we recruit and build upon a diverse cohort of panelists, to gain and act on their insights and experiences. The first phase of our recruitment of panelists will therefore be targeted. Over time, and through collaborative working with partners in our Places, our objective is to recruit a representative sample of the population, with whom we can engage alongside the self- selecting engagement partners from existing forums.

9.3 At the November meeting of the Board a further update on the development and implementation of the ICBs Public Engagement Framework will be presented to the Board.

10. Freedom to Speak Up Guardian

10.1 Following a review of our Freedom to Speak Up Guardian arrangements and discussion between the Chief People Officer, Director of Nursing and Care and Assistant Chief Executive, it has been agreed to propose to the Board that the ICB Associate Director of Workforce becomes the ICB Freedom to Speak Up Guardian, replacing the current incumbent of that position (Assistant Chief Executive). This individual will have direct access to the Chief Executive, Chair and Directors on the Board to raise any concerns.

10.2 The Board is asked to support the appointment of the Associate Director of Workforce as the Freedom to Speak Up Guardian.

10.3 Following agreement from the Board, the ICB website will be updated to reflect this change.

11. Commitment to achieve Net Zero

11.1 Sustainable transformation across an organisation requires leadership and engagement from board-level staff as part of the ongoing work around the ICBs Green Plan[3] and our ambition to achieve Net Zero, the ICB has agreed to fund a bespoke Board-level Net Zero Leadership Training for the ICB Board. An interactive 2-hour training workshop[4] will be designed for the ICB and the opportunity to attend this workshop will be extended to Board members across the system and members of the Integrated Care Partnership.

11.2 It has also been agreed that all ICB staff will be required to undertake the ESR module 'Building a Net Zero NHS' as part of their statutory and mandatory training. We believe we are amongst the first ICBs in the country to make this commitment.

12. MOU Delegation Agreement with NHSE

12.1 A Memorandum of Understanding (MOU) between NHS Cheshire and Merseyside ICB and NHS England (NW Region) has been included within the ICB Governance Handbook.[5] The MOU sets out the arrangements between NHS England (NHSE) and the system in respect of the System Oversight Framework (SOF). It provides clarity on the expected oversight arrangements and support offers and escalations processes in respect of the four segmentations of the framework. In addition, the MOU describes the relationships between the system and NHSE regional team and the interfaces that underpin how the ICB and NHSE will work together to discharge their duties. It is anticipated that whilst this document begins to set out these arrangements, a more detailed Operating Model will further develop these relationships and ways of working for the future.

13. Technical Constitution changes

13.1 Following commencement of the Health and Care Act (2022) a review of the model constitution that was published by NHS England (NHSE) in May 2022 has been undertaken by NHSE. The review has identified several small amendments which NHSE have asked ICBs to make.

13.2 These changes relate to minor technical references to various sections of the Act, and one clarification on the definition of Health Care Professional. As these are minor technical changes, NHSE have advised that they do not fall within the scope of the guidance for ICBs making amendments to their constitutions.

13.3 The ICB Constitution has therefore been amended as outlined above and the updated version has been submitted to NHSE and published on the ICB website.[6]

[3] https://www.cheshireandmerseyside.nhs.uk/about/green-plan/
[4] https://sustainablehealthcare.org.uk/net-zero-board-level-training
[5] https://www.cheshireandmerseyside.nhs.uk/media/cpxnk43g/cm-mou-1st-july-2022.pdf
[6] https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/constitution/

14. The link between investing in health and economic growth

14.1 An interesting report that I would like to draw the Boards attention to is that which has recently been released by the NHS Confederation and entitled 'The link between investing in health and economic growth'.7 The report outlines that growth in healthcare investment has a clear relationship with economic growth, with analysis showing that for each £1 spent per head on the NHS, there is a corresponding return on investment of £4 – showing an economic benefit to investing in the national health service, and that spending on the NHS should be regarded as investment rather than a cost.

14.2 Interestingly the report outlines that investing in the NHS has potential to support the population to improve health, with the most direct link being observed is that investing in primary care workforce shows links to reduced A&E attendances and non-elective admissions, both of which are signals of ill health and in turn influence workforce participation.

14.3 In addition, the NHS itself has a powerful role as an employer. Half of NHS spending is on workforce and the NHS is the largest employer in England. The role of the NHS as an employer is especially important in more deprived areas. This has been recognised in our role as a local Anchor Institute.

14.4 We will look to review this report further and see how its analysis can be turned into tangible actions for the ICB.

15. Police and Crime Commissioner Merseyside

15.1 I have recently been invited to sit on the Merseyside Strategic Policing and Partnership Board.[8] Chaired by Emily Spurrell, the Police and Crime Commissioner for Merseyside, the Board focusses on key policing and community safety issues across Merseyside and ensures the priorities set out in her Police and Crime Plan are being delivered. Many of these priorities crosscut with those of the ICB and our duties to help protect the most vulnerable in society.

15.2 I will be presenting an update to the Strategic Policing and Partnership Board on the work and priorities of the ICB at its next meeting on the 25 October 2022, and I look forward to working closely with partners on this Board to achieve our common goals.

16. LUFHT Update

16.1 At the time of writing this report, Liverpool University Hospitals NHS Foundation Trust (LUFHT) was about to embark on the final part of its 24-day plan in which patients from the old site have been moved into the new Royal site as part of a carefully planned operation.

[7] https://www.nhsconfed.org/publications/analysis-link-between-investing-health-and-economic-growth
[8] https://www.merseysidepcc.info/down-to-business/meetings-decisions/strategic-policing-and-partnership-board/

16.2 The final part of this plan was the move of the Accident and Emergency (A&E) Department from the old department, which closed its doors to walk in patients and those arriving by ambulance at 11.59pm on Wednesday 19 October and the new A&E department in the new Royal will opened its doors for patients at 12:00am on Thursday 20 October.

16.3 Despite the current challenges and pressures faced on hospitals, I am pleased to see and hear that the move has gone to plan with uninterrupted patient care continuing to be delivered to a high standard. Congratulations must be extended to the team at LUFHT who have worked incredibly hard to achieve this.

North West Regional Health & Justice and Specialised Commissioning Team

Specialised Service Segmentation

List of services for delegation and suggestions for NW Commissioning footprints

Service segmentation

- Service line segmentation is displayed in columns, mapped to NHS England's National Programmes of Care :
  - The first two columns make up the total list of services that will delegate to ICSs included the Roadmap to integrate specialised services of care within Integrated Care Systems.
  - The first column is the list of services we are suggesting it makes sense to plan at an ICS footprint in the NW and integrate into system decision making.
  - The second column is a list of services we are suggesting it makes sense for the three ICSs to collaborate on and plan together.
  - There needs to be a consensus view between the NW ICSs on these lists.
  - The third and fourth columns are those services that will not feature in delegation arrangements from April 2023.

Internal Medicine

North West Regional Health & Justice and Specialised Commissioning Team

Single ICS Footprint	Multi-ICS Footprint		NHS England Retained temporarily	NHS England Retained permanently
29S - Severe Asthma	26Z - Adult Highly Specialist Rheumatology		10Z - Cystic Fibrosis	23G - Adult Ataxia Telangiectasia
29M - Interstitial Lung Disease	27Z - Adult Specialist Endocrinology		12Z - Intestinal Failure	29G - Primary Ciliary Dyskinesia Mgmt (Adult)
29E - Management of Central Airway Obstruction	24Z - Specialised Dermatology		11T - Renal Transplant	11A - Atypical Haemolytic Uraemic Syndrome
29A - Pulmonary Vascular Services	01J - Anal Cancer		29V - Complex Home Ventilation	12A - Autologous Intestinal Reconstructn (Adult)
13C - Inherited Cardiac Conditions	01V - Biliary Tract Cancer			16B - Behcets Syndrome (Adult & Adol)
13B - Cardiology (EP and Ablation)	01W - Liver Cancer		13U - Cardiac Networks	29Q - Chronic Pulmonary Aspergillosis (Adult)
13H - Cardiac MRI	19V - Pancreatic Cancer		11N - Renal Networks	M23 - Complex Ehlers Danlos Syndrome
13E / 13Z - Cardiac Surgery	33D - Distal Sacrectomy for Advanced/Recurrent Rectal Cancer			11D - Encapsulating Peritoneal Sclerosis (Ad)
13A - Cardiology (Complex Device Therapy)				24A - Epidermolysis Bullosa
13F - PPCI (for STEMI)				13N - Heart & Lung Transplantation
13T - TAVI				13V - Ventricular Assist Devices
11C - Access for Renal Dialysis				43S - Stevens-Johnson Syndrome & Toxic Epidermal Necrosis
11B - Renal Dialysis				27A - Insulin Resistant Diabetes
30Z - Vascular				19A - Total Pancreatectomy with Islet Autotransplantat
24Y - Skin Cancer				27B - Islet Cell Transplant (Adult)
27E - Adrenal Cancer				19T - Liver Transplant
33B - Complex Inflamatory Bowel Disease				29C - Lymphangioleiomyomatosis (Adult)
33A - Faecal Incontinence				27C - Pancreas Transplant (Adult)
33C - Transanal Endoscopic Microsurgery				29P - Primary Ciliary Dyskinesia Mgmt (Children)
19Z (inc 19L and 19P) - Complex Liver, Biliary and Pancreas				01F - Pseudomyxoma Peritonei (Adult)
				13M - Pulmonary Thromboendarterectomy
				12D - Small Bowel Transplant
				24D - DNA Nucleoside Excision Repair Disords
				39A - Gastroelectrical Stimulation for Intractable Gastroparesis
				33E - Cytoreductive surgery and HIPEC for Colorectal Cancer
				13G - Adult Pulmonary Hypertension

Blood & Infection

North West Regional Health & Justice and Specialised Commissioning Team

Single ICS Footprint	Multi-ICS Footprint		NHS England Retained temporarily	NHS England Retained permanently
14A - HIV (Adult)	18A - Infectious Diseases		02Z - BMT	18D - HTLV I & II
17Z - Specialist Allergy (all ages)	18E - Bone and Joint Infections		ECP - Extracorporeal Phototherapy	16X - Immunology for adults with Immunodeficiency
	03X - Haemophilia (Adult)		38Xhcc - Haemoglobinopathies (Coordination)	14C - HIV (Children)
	03Y - Haemophilia (Paediatric)		38Xsht - Haemoglobinopathies (Teams)	38Snhp - Haemoglobinopathies (Nat Panel)
			38S - Sickle Cell Disease - Direct Clinical Care	02A - Cryopyrin Associated Periodic Syndrome
			38T - Thalassemia - Direct Clinical Care	02B - Diagnostic Svc for Amyloidosis
			18T - Tropical Medicine	18J - Adult HCID (Airborne) Service
			03C - Castleman's Disease	18L - Adult HCID (Contact) Service
				18U - Infectious Disease Isolation Units
			18N - HCV Networks	03A - Paroxysmal Nocturnal Haemoglobinuria
				16C - Severe Combined Immunodeficiency & Rel Disords
				18M - Paed HCID (Contact) Service
				03T - Thrombotic Thrombocytopenic Purpura
				P23 - Stem Cell Transplant for JIA

Cancer

North West Regional Health & Justice and Specialised Commissioning Team

Single ICS Footprint	Multi-ICS Footprint		NHS England Retained temporarily	NHS England Retained permanently
29B / 29Z - Complex Thoracic Surgery	41S - Surgical Sperm Retrival		01X - Penile Cancer	01A - Breast Radiotherapy Injury Service
01C - Chemotherapy	41U - Urethral Reconstructive Surgery		01O - Bone Sarcoma	01I - Choriocarcinoma Service
04F - Gynae Cancer	01R - Radiotherapy (adult)		01L - Soft Tissue Sarcoma	01D - Ev-vivo Partial Nephrectomy
01M - Head and Neck Cancer	51R - Radiotherapy (paed)		01P - PET-CT	01B - Proton Beam Therapy
01N - Kidney Bladder & Prostate Cancer	01S - SRS/SRT		02C - CART and ATMPs	01G - Retinoblastoma
01U - Oesophageal and Gastric Cancer	01K - Malignant Mesothelioma			
	01Y - Other Rare Cancers		51N - Radiotherapy Networks	
	01Q - Brain and CNS Cancers			
	01Z - Testicular Cancers			
	23A - Paediatric Oncology			
	01T - Teenage & Young Adult Cancer			
	41P - Prosthetic Penis Implants			

Trauma

North West Regional Health & Justice and Specialised Commissioning Team

Single ICS Footprint	Multi-ICS Footprint		NHS England Retained temporarily	NHS England Retained permanently
08O - Specialised Neurology	31Z - Highly Specialised Pain Management		08F - Neurosurgical Low Vol Procedures (Regional)	08E - Neurosurgical Low Vol Procedures (Natl)
08P - Neurophysiology	37C - Artificial Eye Services		08G - Neurosurgical Low Vol Procedures (Centres)	08U - TcMRgFUS
08R - Neuroradiology	34R - Specialised Orthopaedic Revisions		05C - Specialised Communication Aids	37E - Limbal Cell (Holoclar) treatment for Eye Injuries
08S - Neurosurgery	32D - Middle Ear Implants		05E - Specialised Environmental Controls	06N - Spinal Cord Injuries Network
08T - Mechanical Thrombectomy	32A - Cochlear Implants		06A - Spinal Cord Injuries	37D - Retinal Gene Therapy
37Z - Specialised Opthalmology (Adult)	34T - Major Trauma (Paeds)			08B - Rare Neuromuscular Disords Diagnosis
34A - Specialised Orthopaedics (excl revisions)	08Y - Neuropsychiatry		34Na - Major Trauma (Networks - Adult)	29F - ECMO (Respiratory - Adult)
32B - BAHAs			34Nb - Major Trauma (Networks - Paed)	40A - Hand and Upper Limb Transplant
06Z - Complex Spinal Surgery			ACN - Adult Critical Care Networks	08D - Neuromyelitis Optica
34T - Major Trauma (Adults)			06N - Spinal Surgery Network	01H - Ocular Oncology (Adult)
23N - Specialised Opthalmology (Paed)			08N - Neurosciences Network	37A - Ophthalmic Pathology
07Z - Complex Rehabilitation				37B.- Osteo-Odonto Keratoprosthesis for corneal blindness
05P - Specialised Prosthetic Limbs				32E - Auditory Brainstem Impants for Children
ACC - Adult Critical Care				28Z - Hyperbaric Oxygen Therapy
				09A - Specialised Burns (Adult)
				09C - Specialised Burns (Paed)
				09N - Burns Networks
				44A - Gonadal Tissue cryopreservation for CYP at high risk of gonadal failure due to treatment or disease

Women & Children

North West Regional Health & Justice and Specialised Commissioning Team

Single ICS Footprint	Multi-ICS Footprint		NHS England Retained temporarily	NHS England Retained permanently
04A - Severe Endometriosis	13X - Adult CHD (Non Surgical)		04K - Complications of vaginal mesh	20A - Alkaptonuria (Adult)
04D - Urinary Incontinence/Genital Prolapse	13Y - Adult CHD (Surgical)		04L - Congenital Abmnormalities of Female Genital Tract	H23 - Alstrom Syndrome
23E - Paediatric Endocrinology & Diabetes	15Z - Cleft Lip and Palate		16Y - Immunology for Children with Immunodeficiency	23J - Ataxia Telangiectasia (Children)
NIC - Neonatal Critical Care	04C - Foetal Medicine		F23 - Perinatal Post Mortem & Pathology	16A - Autoimmune Paediatric Gut Syndrome
04P - Complex Termination of Pregnancy	36Z - Metabolic Disorders			20B.- Bardet Biedl Syndrome
17Z - Specialist Allergy (all ages)	23Y - Highly Specialist Paediatric Pain Mgmt		13W - Congenital Heart Disease Network	36A - Barth Syndrome
	E23 - Highly Specialist Paediatric Palliative care		NIN - Neonatal Critical Care Network	36B - Beckwith-Widemann Syndrome with Macroglossia
	23B - Paediatric Cardiac Services		PIN - Paediatric Crit Care & Surgery Network	D23 - Bladder Exstrophy (Children)
	23P - Paediatric Dental Surgery			K23 - Complex Childhood Osteogenesis Imperfecta
	23D - Paediatric ENT			08A - Complex Neurofibramatosis Type 1
	23F - Paediatric Gastro HPB and Nutrition			B23 - Complex Tracheal Disease
	23Xb - Paediatric Gynae Surgery			N23 - Congenital Hyperinsulinism
	23H - Paediatric Haematology Services			15A - Craniofacial
	04G - Abnormally Invasive Placenta			29D - Primary Ciliary Dyskenesia (Diagnosis)
	23M - Paediatric Neurosciences			R23 - ECMO (Respiratory - Neonates; Infants and Children)
	07Y - Paediatric Neurorehabilitation			36F - CLN2 Disease
	08J - Selective Dorsal Rhizotomy			36C - Lysosomal Storage Disorders
	23Q - Paediatric Orthopaedics			26A - McArdles Disease
	PIC - Paediatric Critical Care			20D - Mitochondrial Donation service
	23R - Paediatric Plastic Surgery			08C - Neurofibramatosis Type 2
	23S - Paediatric Renal Services			12B - Paediatric Intestinal Pseudo-Obstruction
	23T - Paediatric Respiratory Services			13J - Paediatric Pulmonary Hypertension
	23W - Paediatric Rheumatology Services			36D - Rare Mitochondrial Disorders
	18C - Infectious Diseases (Children)			27D - Severe Acute Porphyria
	23Xa - Specialist Paediatric General Surgery			08M - Spinal Muscular Atrophy
	23Z - Paediatric Urology			43A - Inherited White Matter Disorders (Adult)
	35Z - Morbid Obesity (Children)			43C - Inherited White Matter Disorders (Child)
	20H - Pre-Implantation Genetic Diagnosis			T23 - Multiple Sclerosis Mgmt for Children
				U23 - Ope Foetal surgery to treat foetuses with Spina Bifida
				C23 - Specialist Paediatric Liver Disease
				18K - Paed HCID (Airborne) service
				20C - Stickler Syndrome (Diagnosis)
				A23 - Vein of Galen Malformation
				Q23 - Wolfram Syndrome
				29H - Alpha 1 Antitrypsin services
				04U - Uterine Transplantation
				04J - Urinary Fistulae (Gynae)

Mental Health

North West Regional Health & Justice and Specialised Commissioning Team

Single ICS Footprint	Multi-ICS Footprint		NHS England Retained temporarily	NHS England Retained permanently
22Sb - Low & Medium Secure MH & LD (excl LD; ASD; WEMS; ABI and Deaf)	22E - Eating Disorders (Adult)		22Sg - Low & Medium Secure (Deaf)	22Ua - High Secure MH
22Sc - Low & Medium Secure ASD	22P - Perinatal Mental Health		22Sf - Low & Medium Secure (ABI)	22Ub - High Secure LD
22Sd - Low & Medium Secure LD			22Se - Low & Medium Secure (WEMS)	22G - Veterans PTSD
23Ka - Tier 4 CAMHS (Adolescent)			22F - Severe OCD & BDD	22B - CAMHS (Deaf)
23Kb - Tier 4 CAMHS (ED)			22D - Specialised Mental Health (Deaf)	22V - Psych. Inpatient for severe and complex unexplained physical symptoms
23L - Tier 4 CAMHS (Low Secure)			22T - Severe Personality Disorders	22O - Offender Personality Disorders
23O - Tier 4 CAMHS (PICU)			24F - Medium Secure CAHMS	
23U - Tier 4 CAMHS (LD)			24E - CAMHS (Under 13)	
23V - Tier 4 CAMHS (ASD)				
24C - Forensic CAMHS				
YYY - Specialised MH EPCs				

Other services

Single ICS Footprint	Multi-ICS Footprint		NHS England Retained temporarily	NHS England Retained permanently
			42A - Gender: Genital Surgery - trans feminine	
			42B - Gender: Genital Surgery - trans masculine	
			42C - Gender: Chest Surgery - trans masculine	
			42D - Gender: Non Surgical	
			42E - Gender: other surgery	
			22Z - Gender Identity (adult)	
			22A - Gender Identity Development (Paed)	
			20Z - Specialist Clinical Genomics	
			20G - Genomics Laboratory Testing Services	
			MOL - Molecular Diagnostic Services	

NORTH WEST IMAGING ACADEMY

TRAINING HUB

We are delighted to announce the launch of the North West Imaging Academy (NWIA).

In 2021, following the publication of the Richards Review for Diagnostic Services, a North West team, led by Health Education England (HEE), comprising NHS Trusts, Consultant Radiologists, Radiographers, Trust Workforce Leads, Universities involved in imaging education and training, Imaging and Cancer Alliance Workforce Leads came together to collaboratively design the model for a new NWIA supported by national funding of £2.8 million. The Academy comprises a consortium of delivery providers including NHS Trusts, Universities and the North West School of Radiology (HEE).

The model developed by the North West team has been praised by the national diagnostics team as being innovative, ambitious and designed to deliver the ambition of the Richards Review for imaging services.

"The NHS is facing one of its most challenging eras since its inception. Pivotal to how it meets these challenges will be how it maximises the benefits of diagnosing patients earlier and more accurately. To do this it needs a highly skilled imaging workforce, at the forefront of a technology revolution. The NWIA is already helping us to deliver higher numbers of trainees and Allied Health Professionals, delivering exceptional high-quality education, using innovative methods, and improving the learner experience."

Dr Alistair Craig
NW Regional Imaging Clinical Advisor NHSE

Key drivers that informed the development were to address diagnostic throughput capacity, workforce shortages, new approaches to education and training, workforce transformation models, with the overarching aims of reducing health inequality and improving outcomes across all areas of the North West. Monies were awarded to span the range of imaging modalities and workforce development and enhancement through professional development.

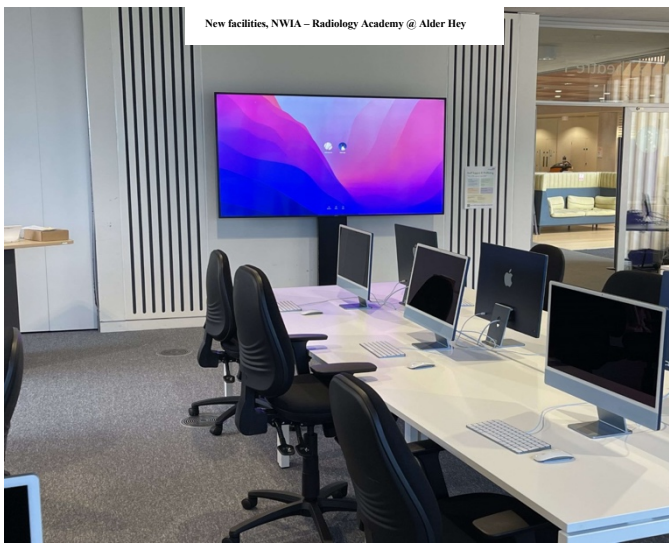
Initial objectives were to:

- support the expansion of radiologist training, improve teaching for ST2 and 3 and provide additional capacity for developing reporting skills;
- develop multiprofessional education for radiographers and wider professional groups;
- increase independent reporting capacity and instigate a process of accreditation to evidence the capabilities of trainees and reporting radiographers;
- lead regional standard setting for radiographer reporting.

These are our early headlines.

In August 2022, the North West School of Radiology (NWSOR) will see an increase from 33 to 39 Specialist Trainees (ST1) in Radiology, which is important for the growth in the future consultant workforce. Innovative approaches to dealing with placement capacity by having a 4-month placement approved by the Royal College of Radiologists at North West Imaging Academy @ Edge Hill University Medical School has facilitated this.

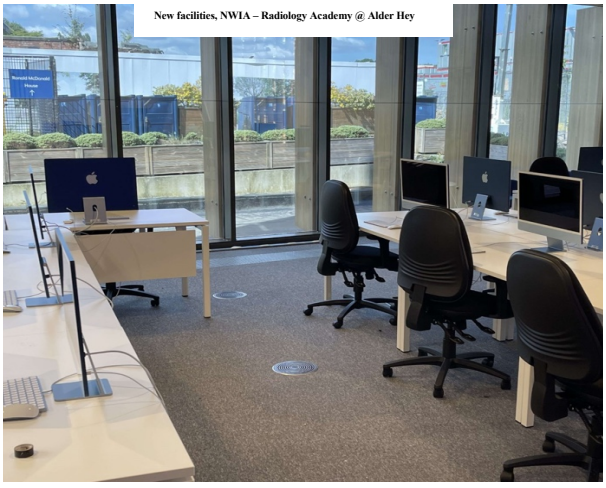
Both Alder Hey Children's Hospital and East Lancashire Teaching Hospital were awarded funds to develop satellite education facilities that will link to the existing site at EHUMS. These additional Imaging Academy facilities offered will also provide enhanced training opportunities for ST2-3, allowing them to develop their knowledge and skills in more specialist areas of imaging more locally.



New facilities, NWIA – Radiology Academy @ Alder Hey

"Developing programmed specialty year group teaching across linked classrooms represents an innovation not solely within the New Academies construct but also within School of Radiology teaching nationally. Educators working within an interconnected learning network maximise their influence and cater to more learners. The initiative represents a potential exemplar in digital education that aims to compliment the learning experiences occurring within clinical placements. We hope today's clinicians can become tomorrow's educators so that today's learners can become tomorrow's clinicians."

Dr Jana Suntharanathan
Head of the North West School of Radiology



New facilities, NWIA – Radiology Academy @ Alder Hey

"ELTH are delighted to host a prestigious NW Imaging Academy site – the Radiology Academy @ELHT. It enables us to be at the forefront of diagnostics training, facilitating the development of specialist knowledge and skills within the region and equipping the next generation of health professionals to deliver Safe, personal, and effective care to the Northwest."

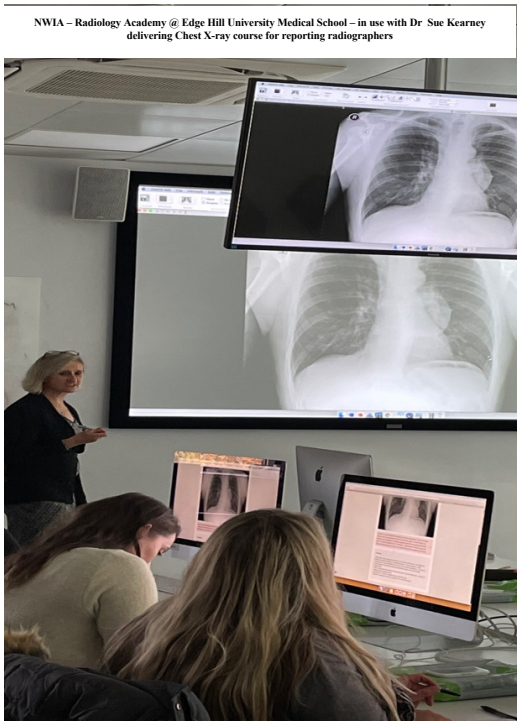
Dr Ruth Smith
Consultant Obstetrician and Gynaecologist
Director of Medical Education
East Lancashire Hospitals NHS Trust

The Radiology Academy @ Edge Hill Medical School (EHUMS) has a well-established IMac lab, that is currently undergoing some expansion. Additionally, we are also investing in imaging software which will provide a cloud-based simulation environment for development of reporting skills and this is expected to be installed ready for use in the autumn. This will provide opportunity for all those engaging in radiology reporting to develop/enhance such skills in a safe, supportive environment, out with the traditional hospital setting. The Radiology Academy @ EHUMS is working closely with NWSOR and the satellite centres to test the facilities with the aim of them becoming operational for teaching in November 2022.

As well as providing additional training capacity for radiologists, the Radiology Academy @ Edge Hill University Medical School will provide opportunity for clinical professional development courses for the wider imaging workforce. Early professional development courses identified as priorities to be delivered in year 1 across these sites are chest X-ray and MSK updates for reporting radiographers, early identification of lung cancer (Cancer & Diagnostics Priority), nasogastric tube location, paediatrics and ultrasound imaging for medics to cite a few.

"I am delighted to be part of this exciting development which enables the delivery of high quality multi-professional education in imaging across the NW. This allows learners to experience teaching in dedicated environments close to their workplace. The interlinking of these facilities allows this teaching to be delivered by experienced tutors from any individual remote site. I believe that this allows the equitable provision of teaching that will improve the educational experience for all imaging professionals."

Dr Sue Kearney
Consultant Radiologist Lancashire Teaching Hospitals NHS Trust & Clinical Director of the Radiology Academy @ Edge Hill Medical School



NWIA – Radiology Academy @ Edge Hill University Medical School – in use with Dr Sue Kearney delivering Chest X-ray course for reporting radiographers

Funding was also provided to a variety of Trusts to provide local education and training facilities that will provide a local environment for private study and on-site imaging education. Several of these are now in operation across the North West region.

Although Ultrasound examinations form about a quarter of all diagnostic medical imaging procedures, ultrasound education and training has encountered significant challenges in recruiting and retaining Sonographers over many decades. The Universities of Cumbria and Salford were successful in being awarded monies to develop a collaborative ultrasound academy. The aim of this is to develop primary training in ultrasound through expanding their direct entry programme, whilst maintaining opportunities for qualified radiographers to move into this modality. The Ultrasound Academy has been able to use the HEE investments to create Ultrasound Skills Hubs at each university. These are being used not only to grow the numbers of new sonographers being educated but also to allow CPD ultrasound training for a variety of professional groups.

Pan view ultrasound simulation suite, University of Cumbria

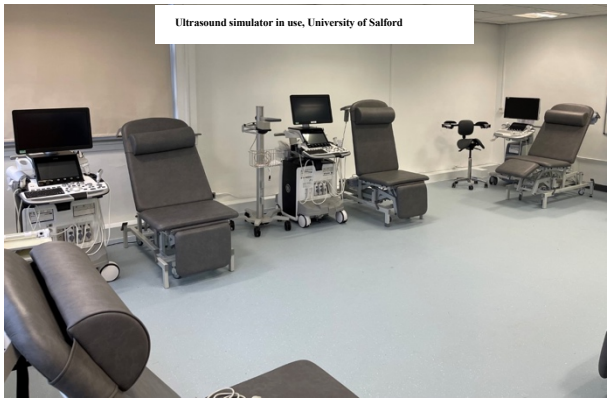
The academy consists of the hub simulation facilitates at both universities but also dedicated spoke clinical training facilities within a variety NHS Trusts and a clinic run at Salford. Together these are able to provide a realistic clinical and simulated learning experiences which allow students to learn the complex psychomotor and patient care skills needed to educate sonographers in a safe environment free from many of the pressures of a busy clinical service.

Ultrasound simulator in use, University of Cumbria

The collaboration between the 2 universities will ensure resources available for ultrasound education are used both sustainably and effectively across the North West region.

"It has been refreshing and motivating to work together with partners to tackle this very difficult workforce issue. We have been delighted to see that some of the Trusts who have been working with us from the start of the project, now do not have any issues with recruiting sonographers and they are fully staffed. The time and efforts they have made to train and grow their own sonographer workforce are showing a significant payback for them."

Charles Sloane (University of Cumbria)
and Claire Mercer (University of Salford).



Ultrasound simulator in use, University of Salford

The University of Liverpool Department of Medical Imaging was awarded monies to develop MRI and CT courses for radiographers to enhance the workforce. They are due to run additional courses in 2022-23 offering a further 40 places (20 per modality). The modules have now been validated by the University as a Postgraduate Certificate in Cross-sectional Imaging and accreditation is now being sought from the College of Radiographers.

UNIVERSITY OF LIVERPOOL

"The University of Liverpool is very pleased to have had the opportunity to work with the North West Imaging Academy and co-designed these two CT and MRI module to meet the current and future service needed. They are designed to provide education and training in CT and MRI to the radiographer new to either modality who needs to be able to get to the level where they can work as a valuable and competent member of the scanning team.

Each module has been funded to run once a year and will provide places for 20 radiographers from Trusts in the North West. The semester long modules require only 3 days of face to face teaching with the rest of the learning is in the scanning department or online and can be managed around radiographers shift pattens. Huge increases will be required in CT and MRI scans in the next 10 year as the new NHS plans are rolled out. These modules will enable more radiographers to be better trained in CT and MRI and so offer greater quality of service to the patients".

Dr Stuart Mackay
Professional Lead for Diagnostic Radiography & Director of Studies MSc (pre-reg) Diagnostic Radiography Programme, University of Liverpool School of Health Sciences

Bolton NHS Foundation Trust are progressing well after being funded to undertake a scoping exercise to explore and present opportunities for the NWIA to support access to higher education for Imaging Support Workers, considering ways in which Level 2 or 3 occupation specific qualification(s), such as an apprenticeship could be accessed to increase take-up. The project will also consider how competency-based development and other role specific local training which can escalate progression into senior support worker roles and will undertake scoping nationally to identify available online learning to establish how that can support career progression as part of the escalator pathway.

The NWIA project is coordinated by the North West Imaging Academy Training Hub (NWIATH), which is based at Edge Hill University Medical School.

The NWIATH works closely with HEE and delivery providers to promote the functions and activities of the wider NWIA to maximise uptake of education and training opportunities and effective use of the resources funded, to quality assure the education and training provided and oversee the quality management of the NWIA. The Hub reports to the NWIA Governance Board at which monthly reports on progress and return on investment are considered. The Hub is also leading on the development of a learning needs assessment tool (LNAT), that will be used to inform the strategic priorities for education and training required to inform future needs. The initial phase of this is now complete and work is commencing with the workforce leads to further develop this LNAT.

"Edge Hill University Medical School is proud to host both the North West Imaging Academy Training Hub and the Radiology Academy. The establishment of the NWIA provides a unique opportunity to enhance the multi-professional imaging workforce in the North West. The excellent state of the art facilities will allow us to offer many high-quality courses linked to workforce needs with options to study in a geographically convenient location".

Julie-Michelle Bridson

Director of North West Imaging Academy Training Hub @ EHUMS & Head Postgraduate Medical Education.

And finally,

"I'd like to pass my sincere thanks to the clinicians, educators and experts who have led and supported this important development in the NW. A special thanks goes to my HEE team who have expertly convened partners and providers into an exemplar of a collaboration. I look forward to hearing about the Academy's successes."

Christopher Cutts, Regional Director, HEE in the North West

Save the date:

Saturday 26th November 2022

FIRST NORTH WEST IMAGING ACADEMY CONFERENCE

Venue: Edge Hill University Medical School, Ormskirk

This event will be free and is aimed at ALL IMAGING STAFF

Further details and registration will be issues in September

NHS
Cheshire and Merseyside

Integrated Care Board Report

27 October 2022

Place Director Report – Cheshire East

Agenda Item No	ICB/10/22/**06**
Report author & contact details	Mark Wilkinson, Place Director (Cheshire East)
Report approved by (sponsoring Director)	-
Responsible Officer to take actions forward	Mark Wilkinson, Place Director (Cheshire East)

Place Director Report – Cheshire East

Executive Summary	Each host Place is required to produce a Place Director's Report for consideration by the Cheshire and Merseyside Integrated Care Board. The Cheshire East Place Director report aims to provide an overview of the Cheshire East Place, its successes, its partnership working and its challenges.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X				
Recommendation	**The Board is asked to:** • **note** the contents of the report and presentation.				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	X		x		
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
		X	X	X	
Appendices	**Appendix A**	Cheshire East Place Director Presentation			

Moving forward, together

#BecauseWeCare
Cheshire East Partnership

Welcome to Cheshire East

NHS Cheshire and Merseyside Board
27 October 2022

#BecauseWeCare
Cheshire East Partnership

“Cheshire East is doing well on most measures compared to national and regional comparisons. This is because there are areas of significant wealth masking large areas of deprivation.

Whilst deprivation exists across Cheshire East, we are focusing today on Crewe.

We want to ensure widespread understanding of our challenges and the fact that there is a once in a generation opportunity to make a difference linked to HS2.

It is incumbent on all of us to ensure that the economic regeneration is matched by regeneration of health and wellbeing. In other words that Crewe people benefit.

In Cheshire and Merseyside we are unusual – the second biggest population, challenges more akin to the South East in terms of the social care market and deprivation as marked as other North West areas. This requires a place specific approach that we introduce today.”

Dr Lorraine O’Donnell – Chief Executive, Cheshire East Council

Mark Wilkinson – Cheshire East Place Director, NHS Cheshire and Merseyside

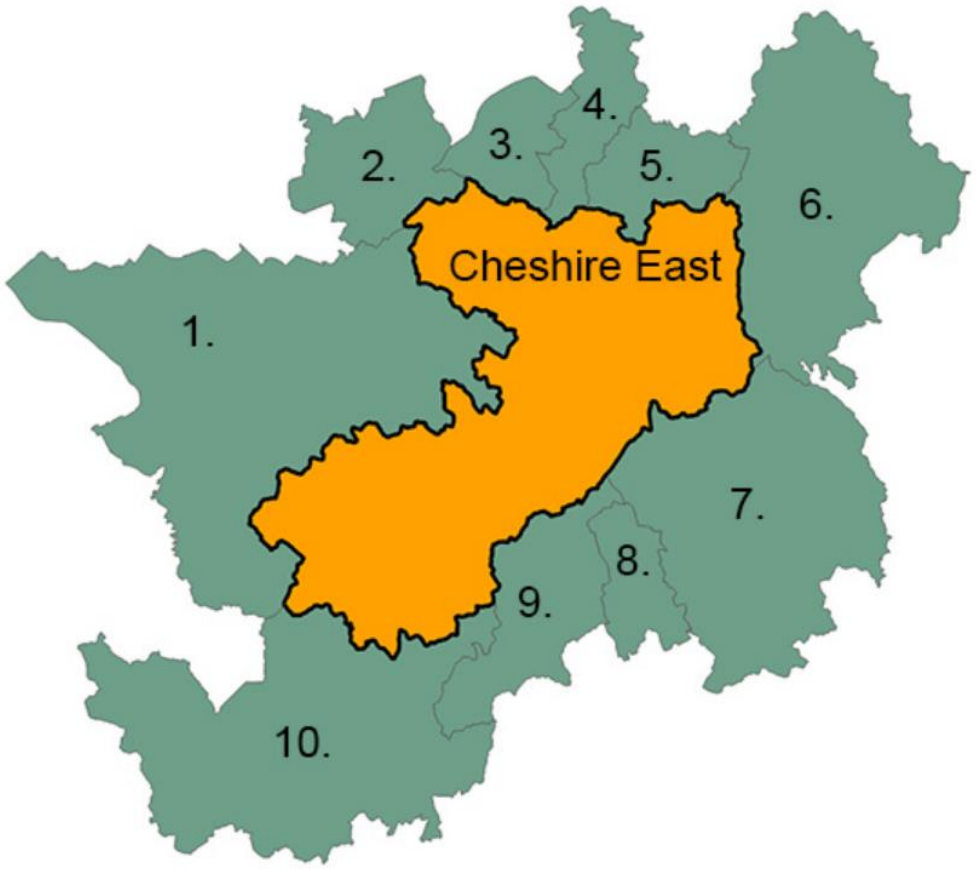
Cheshire East the place

#BecauseWeCare
Cheshire East Partnership

- Major towns:
  - Crewe
  - Macclesfield
- Mix of urban and rural
- C.400k people
- Population density 342 residents/km^2
- Second biggest population in Cheshire and Merseyside

Cheshire East ‘border lands’

#BecauseWeCare
Cheshire East Partnership



Eight out of ten adjacent local authorities are in Greater Manchester, Derbyshire, Staffordshire, or Shropshire.

Cheshire East our population

#BecauseWeCare
Cheshire East Partnership

Population of Cheshire East is estimated to grow by **31,000/8%** with the largest increase in over 65 age group	Average age **43.6 years** (2011 Census) - by 2030, average age is expected to be 47 years	We have fewer **working age and under 16s** than North West or national average
17.5% of residents have a long-term health condition or disability	More than **500** cared for children and **360+** care leavers	**40,003** residents are 'unpaid carers'
93.6% class themselves as White British	**3%** of Cheshire East households have members for whom English is not the main language	**5.1%** were born outside the British Isles, with **2.7%** born outside the EU

Cheshire East Council

#BecauseWeCare
Cheshire East Partnership

- Third largest local authority in the North West and fifteenth largest in the country
- Delivering c. 500 services
- C. £300 million annual budget
- 82 councillors representing 52 wards
- Labour / Independent joint administration. 5 conservative MPs
- Commitment to be a carbon neutral organisation by 2025

Council services in Cheshire East

#BecauseWeCare
Cheshire East Partnership

Strong foundations in primary care

#BecauseWeCare
Cheshire East Partnership

	National %	Cheshire and Merseyside %	CHESHIRE EAST %
Overall experience of your GP practice	72	74	**78**
Satisfied with the appointment offered	72	73	**79**
Satisfied with the appointment process	56	55	**64**
How easy to get through to someone at your practice	53	51	**57**
Are receptionist staff helpful?	82	83	**86**
Trust and confidence in your healthcare professional	93	94	**95**
Good experience of out of hours services	50	50	**56**
Easy to use your practice website	67	68	**70**

Moving forward, together

Population health

#BecauseWeCare
Cheshire East Partnership

Health Profiles for Electoral Wards plus Primary Health and Social Care Areas February 2021

The chart below shows how the health of people in Cheshire East compares with the rest of England.

#	Indicator	Data Type	Time Period	Nantwich: Wrenbury	Nantwich: Bunbury	Nantwich: Audlem	Nantwich: Nantwich South and Stapeley	Nantwich: Nantwich North and West	Crewe: Wybunbury	Crewe: Shavington	Crewe: Willaston and Rope	Crewe: Wistaston	Crewe: Crewe South	Crewe: Crewe West	Crewe: Crewe Central	Crewe: Crewe St Barnabas	Crewe: Crewe North	Crewe: Crewe East	Crewe: Leighton
1	Total Population	Number	Mid-2017	4628	5156	5412	9485	8698	5667	4162	4782	8908	11999	10721	6587	5865	4737	15250	5245
2	BME Population	%	2011	1.2	0.9	1.4	2.4	1.8	2.8	1.7	1.6	1.9	8.5	4.4	7.3	4.1	3.3	3.7	3.9
3	Proficiency in English	%	2011	0.1	0.2	0.1	0.1	0.2	0.1	0.2	0.2	0.3	4.9	2.1	5.3	2.5	1.6	1.0	0.7
4	Population under 16	%	Mid-2017	14.8	16.7	16.1	19.2	15.9	19.5	15.6	15.8	15.0	19.3	20.7	23.7	26.0	22.0	18.8	20.3
5	Population aged 65 and over	%	Mid-2017	25.4	21.2	27.8	22.6	26.6	18.8	26.5	25.3	27.0	12.3	15.7	9.7	13.3	18.5	19.0	10.3
6	Pensioners living alone	%	2011	22.6	28.5	23.3	30.0	40.4	23.3	31.5	24.4	26.5	35.6	34.3	46.4	39.4	32.7	33.6	15.7
7	Older people with low income	%	2015	8.3	7.4	8.1	8.5	13.0	5.9	6.8	5.3	7.5	17.7	15.4	27.5	30.6	13.5	15.0	5.6
8	People with low income	%	2015	6.8	6.2	5.8	6.0	12.2	4.3	5.0	4.1	6.2	16.9	15.7	24.1	28.8	18.9	15.3	4.0
9	Children in poverty	%	2015	8.0	8.0	5.0	6.5	15.3	3.7	5.2	4.5	7.4	23.4	23.4	32.4	36.6	31.6	26.0	5.5
10	Long term unemployment	Rate	2017/18	1.8			0.6	1.3		2.1		0.7	4.5	2.9	8.5	4.8	2.2	3.0	
11	Fertility rate	Rate	2011 - 2015	46.6	45.5	45.3	54.7	63.5	50.3	53.5	46.1	48.1	67.4	61.8	89.5	81.9	73.0	58.1	57.7
12	Low birth weight	%	2011 - 2015	1.0	0.8	0.9	1.7	2.6	1.1	2.2	1.8	1.7	2.3	2.4	2.7	1.4	2.5	2.5	2.1
13	Deliveries to teenage mothers	%	2011/12 - 2015/16	1.2	1.2	1.2	1.2		1.2			3.1	1.7	2.2	2.3	3	2.4	3.8	
14	A&E attendances age 0-4	Rate	2013/14 - 2015/16	251.5	273.5	256.6	324.7	365.5	307.2	298.2	305.3	345.2	364.4	394.9	414.4	423.1	406.0	435.4	361.4
15	Admissions for injury age 0-4	Rate	2011/12 - 2015/16	132.1	150.4	136.3	168.4	170.3	159.0	114.3	134.6	180.7	171.0	209.3	231.6	247.9	213.3	184.5	128.5
16	Emergency admissions age 0-4	Rate	2013/14 - 2015/16	138.5	167.1	145.1	222.5	257.1	201.2	188.0	203.7	226.0	221.6	222.7	217.7	223.5	212.3	253.0	201.5
17	Child development at age 5	%	2013/14	59.1	61.4	60.1	64.0	61.7	66.0	61.5	61.6	56.8	50.6	57.1	51.9	54.5	48.2	50.7	46.6
18	GCSE achievement	%	2013/14	77.5	77.7	77.5	65.1	54.0	76.3	53.5	65.3	65.4	49.8	45.8	41.1	31.5	48.6	49.5	67.0
19	Excess weight age 4-5	%	2015/16 - 17/18	20.1	17.0	18.9	19.6	25.4	16.0	16.9	17.2	20.7	24.2	21.9	24.5	23.8	25.5	21.9	22.4
20	Excess weight 10-11	%	2015/16 - 17/18	27.7	27.1	27.4	27.9	29.8	29.8	29.2	28.0	29.1	36.9	35.4	39.1	40.5	38.6	39.6	32.4
21	Smokers age 11-15	%	2009 - 2012	3.3	1.8	2.6	4.3	3.2	2.7	3.2	2.6	2.8	4.2	3.8	8.0	4.4	4.2	3.3	2.9
22	Smokers age 16-17	%	2009 - 2012	15.9	15.9	14.5	15.0	18.1	13.3	13.4	12.9	12.6	17.6	16.7	24.3	23.2	16.1	16.0	12.1
23	Healthy Eating (adults)	%	2006 - 2008	34.4	33.9	34.3	30.7	30.3	33.2	31.9	32.3	29.1	25.0	24.3	22.5	20.7	23.6	24.0	28.2
24	Obese adults	%	2006 - 2008	21.1	20.9	21.1	22.0	22.5	21.0	23.7	22.3	23.0	24.9	25.5	27.1	27.4	26.8	25.8	24.7
25	Binge drinkings (adults)	%	2006 - 2008	20.6	20.8	20.6	21.0	21.1	21.7	23.0	21.2	19.5	26.7	24.5	24.2	23.1	23.0	21.8	23.2
26	Admissions for alcohol	SAR	2013/14 - 17/18	74.3	75.9	74.5	99.2	111.2	79.9	91.0	84.8	89.7	154.3	136.0	161.2	146.5	147.1	144.0	102.2
27	Self-reported bad health	%	2011	4.4	4.0	5.4	4.3	6.5	3.1	5.4	3.6	4.6	5.0	6.9	6.7	7.9	6.2	6.0	2.3
28	Self-reported illness	%	2011	16.1	14.9	18.6	16.6	21.4	13.3	20.8	16.4	18.2	15.6	19.5	19.0	19.1	19.2	19.9	9.9
29	Hospital stays for self-harm	SAR	2013/14 - 17/18	55.9	51.2	55.2	102.7	150.8	50.7	103.8	84.2	93.8	176.9	175.3	170.6	211.4	144.1	167.0	106.2
30	Emergency admissions heart attack	SAR	2013/14 - 17/18	85.2	86.6	85.4	86.6	87.5	85.7	85.6	76.3	86.5	139.9	137.9	138.7	144.3	124.2	120.2	87.3
31	Emergency admissions stroke	SAR	2013/14 - 17/18	83.1	83.3	83.2	98.3	106.6	83.2	90.5	92.1	101.4	125.2	134.5	129.0	114.0	121.6	111.6	138.3
32	Emergency admissions respiratory	SAR	2013/14 - 17/18	48.7	49.9	48.8	62.5	67.6	52.1	47.8	42.7	64.3	168.5	197.1	186.8	203.6	145.4	195.2	96.6
33	Emergency admissions hip fracture	SAR	2013/14 - 17/18	104.2	104.2	104.2	94.4	97.6	104.1	102.6	84.1	86.8	124.5	125.4	124.2	110.4	97.1	118.6	86.7
34	Emergency admissions all causes	SAR	2013/14 - 17/18	90.6	95.9	91.3	119.4	126.8	101.1	110.1	101.6	108.4	150.9	153.8	164.4	163.2	152.7	154.1	125.3
35	New cases - breast cancer	SIR	2012 - 2016	99.9	102.7	100.2	105.7	117.0	107.5	104.0	108.5	110.0	131.9	92.6	78.6	103.0	88.9	115.0	111.6
36	New cases - bowel cancer	SIR	2012 - 2016	94.4	95.0	94.5	102.4	108.2	91.1	97.0	99.3	100.9	98.2	119.9	110.6	96.4	96.2	99.1	102.7
37	New cases - lung cancer	SIR	2012 - 2016	78.6	69.0	77.7	65.8	65.7	60.2	87.1	69.2	79.3	120.1	142.4	180.6	161.3	167.6	145.6	85.8
38	New cases - prostate cancer	SIR	2012 - 2016	110.3	102.8	109.5	77.3	69.5	95.2	95.5	103.4	101.7	104.7	78.9	83.0	74.9	96.6	93.3	123.0
39	All new cases cancer	SIR	2012 - 2016	100.3	96.9	99.9	93.8	94.5	91.8	101.5	98.0	100.1	107.8	105.2	108.4	101.1	112.5	110.9	116.5
40	Cancer deaths under 75	SMR	2013 - 2017	61.2	83.1	107.4	81.9	86.0	64.5	112.8	91.3	68.7	159.4	103.9	203.5	148.1	133.8	135.0	72.5
41	Heart deaths under 75	SMR	2013 - 2017	104.5	51.9	80.6	97.9	82.0	44.8	133.2	50.2	112.4	185.1	133.1	216.9	166.1	190.9	123.8	67.1
42	All deaths under 75	SMR	2013 - 2017	81.1	65.0	98.2	79.5	91.8	56.5	104.7	66.7	81.4	151.9	129.4	220.1	153.7	129.6	129.5	63.3
43	Deaths from respiratory diseases	SMR	2013 - 2017	116.5	83.0	118.8	82.4	83.1	75.3	93.1	80.6	75.0	131.8	128.4	268.8	179.8	129.3	144.1	92.5
44	All deaths all ages	SMR	2013 - 2017	87.3	72.1	120.6	96.7	91.7	66.1	83.6	68.1	79.2	121.7	123.6	191.9	123.4	111.0	113.3	91.8
45	Female life expectancy	Years	2013 - 2017	84.4	87.2	81.5	82.7	83.5	89.1	86.3	86.9	85.6	80.0	79.6	76.7	80.0	82.5	81.6	83.4
46	Male life expectancy	Years	2013 - 2017	81.7	82.8	78.9	81.6	80.2	81.6	81.0	82.8	80.9	77.1	77.4	71.7	75.4	77.3	77.4	82.1

#	Indicator	SMASH: Haslington	SMASH: Sandbach Ettiley Heath and Wheelock	SMASH: Sandbach Elworth	SMASH: Sandbach Town	SMASH: Sandbach Heath and East	SMASH: Middlewich	SMASH: Brereton Rural	SMASH: Alsager	SMASH: Odd Rode	Congleton: Congleton West	Congleton: Congleton East	Congleton: Dane Valley	Knutsford: Knutsford	Knutsford: High Legh	Knutsford: Mobberley
1	Total Population	8022	4998	5146	4940	4398	14138	5393	11839	8301	13116	13406	9350	13286	4408	4666
2	BME Population	1.4	2.0	2.2	2.2	1.4	1.5	1.0	2.4	1.1	2.3	1.7	1.9	3.5	3.2	2.5
3	Proficiency in English	0.1	0.3	0.1	0.1	0.0	0.3	0.1	0.2	0.1	0.2	0.1	0.1	0.2	0.2	0.5
4	Population under 16	14.8	19.2	18.4	15.1	15.7	18.5	18.0	17.3	14.0	16.3	18.6	15.8	19.6	16.5	14.5
5	Population aged 65 and over	24.7	15.8	20.5	28.8	26.2	19.1	22.5	27.5	29.2	26.9	23.0	29.8	24.5	27.1	28.9
6	Pensioners living alone	25.1	28.2	27.4	28.8	37.7	30.2	21.8	32.1	24.7	30.5	25.6	27.1	32.6	21.7	23.7
7	Older people with low income	7.6	7.9	7.3	7.5	13.5	12.2	7.9	8.2	7.5	12.3	12.2	6.2	10.5	7.5	6.5
8	People with low income	5.3	4.7	7.3	7.1	10.8	9.2	7.3	9.1	6.3	9.1	12.1	4.5	9.3	5.2	4.6
9	Children in poverty	6.5	4.9	11.7	9.6	13.6	11.2	10.4	12.0	8.1	8.9	17.4	4.4	11.2	4.4	4.1
10	Long term unemployment	1.0	0.9			0.2	1.1	0.5	1.5	1.1	1.1	0.7	1.0	0.7	0.3	
11	Fertility rate	40.0	60.7	58.3	50.3	56.0	60.0	52.0	53.2	53.3	59.3	69.2	47.2	77.2	73.6	69.0
12	Low birth weight	2.3	2.4	2.3	2.4	3.0	1.8	2.2	2.5	2.5	2.2	2.2	1.7	1.4	1.6	1.8
13	Deliveries to teenage mothers						0	0.2	0	0		1.3	0	0	0	0
14	A&E attendances age 0-4	345.9	310.7	312.2	316.3	314.8	363.6	361.6	292.0	381.6	394.6	423.3	301.6	327.6	402.7	399.8
15	Admissions for injury age 0-4	142.1	121.5	125.1	135.7	133.9	125.0	153.8	109.9	167.7	189.4	181.3	124.1	182.8	151.0	157.0
16	Emergency admissions age 0-4	227.5	211.0	200.9	172.7	182.5	279.7	196.2	155.1	204.0	220.0	203.5	192.6	171.3	182.1	183.6
17	Child development at age 5	68.9	69.8	72.5	76.0	66.7	62.4	63.7	59.3	65.2	53.0	57.8	68.6	64.0	60.2	61.4
18	GCSE achievement	71.9	69.8	71.1	71.1	61.7	56.9	71.3	68.1	69.0	64.6	56.4	69.7	66.1	71.1	71.3
19	Excess weight age 4-5	20.3	19.6	19.3	19.3	21.5	22.2	19.0	22.8	20.4	23.0	22.6	17.3	14.3	18.1	18.3
20	Excess weight 10-11	36.0	27.1	27.3	27.8	27.7	32.0	31.5	35.1	35.7	30.8	31.0	22.8	26.5	25.4	25.5
21	Smokers age 11-15	2.5	2.3	2.4	3.0	2.9	2.1	2.6	3.2	4.3	2.7	3.0	4.7	4.2	2.9	2.5
22	Smokers age 16-17	13.9	14.2	13.6	15.3	16.5	15.3	14.5	14.8	14.5	15.4	15.9	21.1	15.5	15.3	14.7
23	Healthy Eating (adults)	31.5	29.0	30.5	32.2	29.3	28.6	32.0	32.4	29.9	30.2	29.5	37.0	34.5	37.7	37.7
24	Obese adults	23.2	21.4	21.3	21.9	23.1	23.5	22.0	18.7	23.3	23.2	23.6	19.0	17.9	19.9	19.5
25	Binge drinkings (adults)	25.7	21.8	20.6	19.1	21.2	21.8	19.2	23.3	19.5	22.3	20.0	21.4	20.9	20.8	20.6
26	Admissions for alcohol	86.7	100.3	95.2	93.8	110.8	121.0	77.1	97.0	82.5	86.5	85.5	66.0	73.9	72.5	71.2
27	Self-reported bad health	4.9	4.2	3.4	5.3	6.4	5.3	3.4	5.0	5.3	5.6	5.0	3.7	4.4	4.7	5.8
28	Self-reported illness	18.3	14.2	16.0	19.7	22.4	17.1	15.4	19.5	20.2	19.6	18.1	15.0	17.2	15.7	21.5
29	Hospital stays for self-harm	63.4	107.2	102.0	97.5	117.0	160.6	77.5	152.8	79.9	105.9	145.9	79.9	56.8	62.2	63.0
30	Emergency admissions heart attack	77.7	73.3	79.9	88.2	82.5	108.1	81.0	85.0	86.1	108.9	106.3	70.1	83.1	80.8	77.6
31	Emergency admissions stroke	82.3	109.7	105.3	103.4	113.7	106.0	81.7	88.7	85.3	98.6	104.0	72.5	90.5	90.5	90.9
32	Emergency admissions respiratory	53.6	67.9	62.9	63.1	79.5	123.7	49.4	53.7	51.1	60.7	60.8	37.2	49.9	43.6	42.4
33	Emergency admissions hip fracture	103.8	101.4	97.8	100.9	118.4	101.1	92.7	99.1	96.2	91.4	111.2	81.5	76.5	98.3	100.7
34	Emergency admissions all causes	98.3	114.3	110.6	108.4	118.6	147.2	86.5	100.8	91.7	87.8	90.6	79.9	77.9	85.0	81.9
35	New cases - breast cancer	110.9	121.5	113.0	105.5	122.0	63.6	118.2	83.6	116.1	76.8	73.9	110.6	132.4	97.1	97.3
36	New cases - bowel cancer	77.4	66.3	94.0	123.7	92.7	113.4	100.7	126.9	97.8	103.9	97.1	113.0	122.2	101.0	99.2
37	New cases - lung cancer	75.5	111.5	91.4	78.9	116.9	121.1	71.1	73.5	75.7	94.3	87.9	64.0	96.2	74.3	69.4
38	New cases - prostate cancer	104.9	107.1	117.6	125.7	108.0	89.1	106.5	108.3	101.3	89.4	93.8	97.9	107.4	108.2	106.3
39	All new cases cancer	90.9	105.9	105.3	106.7	111.2	103.4	93.8	99.8	91.5	95.8	92.2	92.0	103.6	99.5	97.5
40	Cancer deaths under 75	70.0	87.5	100.8	115.4	93.3	94.6	58.9	80.4	77.6	108.8	88.3	70.8	89.2	67.0	92.3
41	Heart deaths under 75	73.2	94.5	84.7	70.1	145.9	124.7	91.3	90.9	93.2	96.0	94.7	58.7	92.3	35.1	52.3
42	All deaths under 75	81.5	93.1	96.2	100.5	129.7	102.1	71.0	75.5	78.7	108.2	89.5	60.4	84.4	60.1	89.3
43	Deaths from respiratory diseases	104.6	95.4	106.7	98.0	125.5	115.7	67.2	70.9	101.4	106.0	100.0	77.2	88.9	71.2	85.0
44	All deaths all ages	98.0	78.4	99.0	87.3	94.7	106.6	69.1	79.1	96.7	105.0	97.1	71.6	78.7	103.3	114.1
45	Female life expectancy	83.6	87.2	83.8	83.6	86.3	82.9	86.5	85.8	83.3	83.1	83.7	86.4	86.9	83.1	82.0
46	Male life expectancy	81.3	81.7	78.8	80.5	75.4	78.9	83.3	81.1	81.4	78.4	80.5	83.8	81.1	83.2	77.7

#	Indicator	Wilmslow: Chelford	Wilmslow: Wilmslow West and Chorley	Wilmslow: Wilmslow Lacey Green	Wilmslow: Handforth	Wilmslow: Wilmslow Dean Row	Wilmslow: Wilmslow East	Wilmslow: Alderley Edge	Wilmslow: Prestbury	Macclesfield: Gawsworth	Macclesfield: Sutton	Macclesfield: Broken Cross and Upton	Macclesfield: Macclesfield West and Ivy	Macclesfield: Macclesfield South	Macclesfield: Macclesfield Central	Macclesfield: Macclesfield East	Macclesfield: Macclesfield Hurdsfield	Macclesfield: Macclesfield Tytherington	Poynton: Bollington	Poynton: Poynton West and Adlington	Poynton: Poynton East and Pott Shrigley	Poynton: Disley	Cheshire East	England	
1	Total Population	3905	10011	4875	9573	4619	4429	5033	4338	3919	4166	8937	7965	8466	9288	4427	4448	8664	8599	8313	7589	4573	378846	55619430	Population
2	BME Population	2.5	3.8	6.6	8.4	11.9	8.6	6.0	3.7	1.4	1.3	5.9	2.8	3.7	6.3	2.2	3.2	3.5	1.6	2.3	1.4	2.1	3.3	14.6	Population
3	Proficiency in English	0.1	0.4	0.5	0.3	0.6	0.6	0.3	0.1	0.1	0.1	0.3	0.2	0.6	0.5	0.3	0.5	0.3	0.1	0.1	0.1	0.1	0.6	1.7	Population
4	Population under 16	15.3	20.4	17.6	19.1	18.4	17.8	17.0	15.4	13.8	15.1	19.9	17.5	19.8	16.5	18.2	17.5	16.2	18.2	17.6	14.9	16.0	17.8	19.1	Population
5	Population aged 65 and over	28.7	20.9	20.2	20.0	17.3	26.9	25.8	31.3	30.4	28.0	19.4	22.0	19.1	15.6	19.8	18.3	23.0	22.2	27.8	32.5	26.3	22.5	18.0	Population
6	Pensioners living alone	27.9	31.5	28.6	39.6	22.5	30.2	34.0	24.0	21.8	25.2	28.4	35.6	28.1	42.3	34.9	45.2	29.4	33.5	26.1	24.9	27.3	30.0	31.5	Population
7	Older people with low income	7.5	7.4	15.2	18.0	5.8	2.5	7.9	3.3	5.8	6.9	8.6	16.2	16.8	17.3	10.2	19.3	6.7	9.7	6.6	6.9	6.5	10.2	16.2	Income
8	People with low income	6.2	4.3	12.3	16.5	4.2	2.2	5.2	2.9	4.7	4.8	8.3	13.7	14.3	10.9	9.8	16.6	4.9	7.4	4.9	5.3	6.2	9.4	14.6	Income
9	Children in poverty	4.8	3.9	16.0	20.7	4.3	1.9	4.0	3.4	6.5	2.4	9.8	15.8	17.1	12.9	12.6	20.1	4.9	9.1	4.4	5.7	6.2	12.4	19.9	Income
10	Long term unemployment		0.4	0.8	0.9						0.9	1.7	3.4	3.5	2.7	2.6	3.5	0.9	0.5	1.1	1.3	1.9	1.5	3.6	Income
11	Fertility rate	56.2	73.5	58.1	68.8	56.4	59.3	56.6	48.6	40.9	49.9	62.3	66.4	70.3	69.4	78.0	61.8	45.5	58.3	50.4	52.7	63.4	60.8	63.2	Young People
12	Low birth weight	2.4	1.8	2.7	3.0	3.0	2.1	3.3			2.7	2.6	1.9	2.7	3.1	4.0	4.1	2.5	2.3	2.0	2.6	2.7	2.2	2.8	Young People
13	Deliveries to teenage mothers	0	0	0			0	0	0	0	0.4	0	0	1.8	1.4	1.3	1.3	0	0	0	0		1.0	1.1	Young People
14	A&E attendances age 0-4	391.2	377.3	423.6	474.5	445.1	380.4	377.0	379.8	384.6	397.0	480.3	500.6	456.3	429.7	460.6	463.9	364.5	400.2	416.5	351.1	422.1	385.6	551.6	Young People
15	Admissions for injury age 0-4	174.5	189.1	149.8	192.9	156.6	199.3	203.6	143.9	123.1	134.3	166.6	193.0	182.9	156.2	177.6	179.9	79.0	213.5	129.7	147.3	146.8	168.1	138.8	Young People
16	Emergency admissions age 0-4	188.0	174.9	166.3	210.7	178.2	169.6	195.2	141.9	205.4	215.5	263.9	284.0	263.8	249.8	274.1	276.8	186.7	206.3	204.3	149.7	202.4	213.8	149.2	Young People
17	Child development at age 5	63.6	80.7	67.7	59.5	65.2	78.8	69.5	71.7	60.7	59.3	64.1	60.5	55.4	55.9	60.6	61.1	76.9	63.7	72.0	73.4	67.2	61.8	60.4	Young People
18	GCSE achievement	72.2	74.5	56.0	52.2	51.9	73.1	73.7	80.4	68.1	63.2	74.8	51.9	44.8	60.9	48.7	46.7	75.9	66.2	75.7	73.3	69.0	62.2	56.6	Young People
19	Excess weight age 4-5	19.3	12.9	14.0	17.2	15.1	12.4	21.2	16.8	17.8	18.9	18.2	25.2	23.4	18.0	16.7	16.7	20.2	19.7	16.8	15.1	13.6	20.0	22.4	Lifestyle
20	Excess weight 10-11	25.7	16.2	23.7	30.9	26.7	15.9	25.9	21.4	21.6	22.8	29.7	26.9	28.9	30.2	33.6	33.8	23.3	16.1	29.5	26.5	27.1	29.8	34.2	Lifestyle
21	Smokers age 11-15	2.3	3.0	3.1	4.3	2.3	3.0	3.0	2.8	2.2	5.1	3.3	3.7	4.6	6.0	3.4	4.8	2.1	3.6	3.0	3.3	3.0	3.2	3.1	Lifestyle
22	Smokers age 16-17	14.4	13.0	15.4	16.8	11.5	12.0	14.0	12.9	15.4	18.5	13.7	17.2	17.7	17.2	16.0	20.4	13.1	16.1	13.5	12.5	13.9	15.2	14.8	Lifestyle
23	Healthy Eating (adults)	37.9	39.3	35.9	29.6	32.1	40.2	38.2	40.8	38.3	36.2	31.5	27.2	26.9	30.4	28.6	28.3	34.9	33.6	36.2	36.7	35.6	31.4	28.7	Lifestyle
24	Obese adults	18.5	16.1	19.0	21.0	20.1	15.7	17.2	16.5	19.2	19.7	20.2	22.8	21.9	20.3	21.6	21.8	18.2	20.0	19.6	20.5	20.5	21.5	24.1	Lifestyle
25	Binge drinkings (adults)	20.1	20.7	22.7	21.9	22.9	20.7	19.4	16.6	17.9	19.2	24.9	23.4	25.5	31.3	25.6	24.7	21.8	28.3	21.1	20.5	25.0	22.3	20	Lifestyle
26	Admissions for alcohol	68.4	56.2	70.4	101.2	84.9	55.1	64.4	51.5	62.2	71.9	78.7	115.6	124.2	108.8	113.5	113.9	65.3	78.8	76.9	75.2	80.3	93.3	100	Lifestyle
27	Self-reported bad health	3.8	2.9	6.0	6.3	2.6	2.3	5.0	3.2	3.6	4.2	4.4	6.2	5.9	4.7	4.8	7.2	3.3	4.6	4.3	4.8	4.4	4.9	5.5	Illness
28	Self-reported illness	14.8	13.2	19.0	19.8	11.6	13.5	17.4	14.9	17.2	17.8	15.0	21.6	19.4	15.5	15.9	21.7	14.6	17.1	17.0	18.4	17.3	17.5	17.6	Illness
29	Hospital stays for self-harm	64.5	33.4	53.6	113.1	78.7	31.7	66.8	36.4	68.9	90.2	95.4	163.1	171.5	180.9	208.4	211.7	88.3	62.6	69.5	51.3	51.3	112.1	100	Illness
30	Emergency admissions heart attack	71.1	74.5	74.2	111.2	91.5	67.0	62.2	57.1	64.1	72.9	94.0	108.4	123.7	105.0	72.6	68.8	86.8	89.2	95.2	91.9	89.2	92.4	100	Illness
31	Emergency admissions stroke	91.7	83.9	88.2	96.3	90.1	88.4	92.8	76.9	87.6	92.0	93.9	95.4	114.6	111.7	86.2	83.1	65.0	78.2	80.9	103.2	67.5	95.3	100	Illness
32	Emergency admissions respiratory	40.0	41.1	47.2	89.0	68.8	37.8	36.7	19.7	27.0	40.5	57.6	131.4	128.4	102.7	131.7	134.8	50.2	48.6	55.3	52.4	82.7	75.6	100	Illness
33	Emergency admissions hip fracture	103.7	86.3	86.6	84.7	79.7	94.7	107.8	111.8	72.3	91.6	109.8	98.2	131.6	121.7	86.6	81.6	86.3	91.6	99.3	87.8	88.4	98.4	100	Illness
34	Emergency admissions all causes	75.7	68.6	80.0	106.1	91.4	68.9	67.1	63.9	69.0	77.0	91.7	109.5	114.8	101.9	106.3	106.7	72.0	81.2	86.6	83.7	88.1	103.2	100	Illness
35	New cases - breast cancer	97.7	108.6	97.6	124.2	105.4	114.7	98.2	111.6	128.9	123.8	122.5	120.2	97.9	101.5	99.0	98.7	102.6	102.6	127.8	96.8	130.7	105.4	100	Cancer
36	New cases - bowel cancer	95.4	83.1	124.2	144.7	143.4	88.7	90.2	126.9	96.3	97.1	109.2	93.7	98.7	87.4	94.2	94.9	92.2	69.9	94.9	112.2	112.4	102.8	100	Cancer
37	New cases - lung cancer	59.2	55.6	96.5	141.5	127.8	57.4	44.9	48.4	43.9	52.9	67.4	139.0	115.4	76.4	109.6	113.3	51.2	104.2	46.0	47.3	76.9	87.3	100	Cancer
38	New cases - prostate cancer	101.8	88.2	90.4	86.5	87.1	82.5	95.2	115.3	67.6	68.5	81.5	104.4	78.0	61.8	121.2	127.9	74.9	72.9	138.2	97.1	97.9	95.9	100	Cancer
39	All new cases cancer	93.2	92.0	93.8	108.1	97.5	95.3	87.3	91.4	85.6	88.1	96.5	109.6	103.4	89.3	103.0	104.5	90.1	87.7	97.4	90.3	97.6	98.2	100	Cancer
40	Cancer deaths under 75	56.3	67.5	118.4	81.0	75.5	53.1	62.4	52.5	68.7	85.5	76.5	113.5	112.9	88.0	79.4	141.8	74.2	76.7	69.8	65.7	72.0	89.2	100	Death
41	Heart deaths under 75	88.0	52.1	97.3	125.0	33.6	49.5	52.4	58.7	61.3	55.0	74.7	72.9	133.0	89.7	74.5	102.6	57.1	93.2	48.4	79.1	56.1	90.6	100	Death
42	All deaths under 75	62.3	57.1	119.3	92.2	55.9	55.4	71.1	48.0	63.4	78.5	92.5	108.5	134.2	101.0	90.4	137.4	64.6	84.4	65.3	63.7	71.7	90.4	100	Death
43	Deaths from respiratory diseases	43.3	67.1	139.6	97.2	101.2	48.6	82.7	56.6	65.4	72.5	101.1	90.7	119.0	123.1	124.6	146.8	82.5	107.3	86.0	77.8	63.2	96.9	100	Death
44	All deaths all ages	65.5	68.9	138.8	83.6	93.5	55.7	97.8	64.4	64.8	87.7	127.4	87.9	128.9	102.7	92.1	95.5	74.9	92.7	95.4	97.7	75.9	94.0	100	Death
45	Female life expectancy	84.7	88.0	80.5	85.8	85.1	89.8	83.8	86.6	86.7	85.3	81.8	84.8	81.2	83.9	84.7	82.5	86.6	83.9	84.5	83.1	85.1	83.8	83.1	Death
46	Male life expectancy	84.3	83.1	77.8	80.5	81.6	84.7	82.4	82.4	85.1	80.1	79.1	79.6	75.6	79.0	79.1	78.4	83.1	80.6	80.7	82.0	82.4	80.2	79.5	Death

Quintile 1 - Highest 20% of wards nationally
Quintile 2
Quintile 3
Quintile 4
Quintile 5 - Lowest 20% of wards nationally
Data suppressed to prevent disclosure

Shades of blue used when an indicator has no preferred polarity. I.E when it is not appropriate to say whether a high/low value is good or bad.

Indicator Notes - Data extracted during March 2020 and up to date as of February 2021.
Population 1 Total resident population, 2017 2 % people stating their ethnicity as not White (not any White category), 2011 Census 3 % people whose main language is not English and cannot speak English well or cannot speak English, 2011 Census 4 % resident population aged under 16, 2017 5 % resident population aged 65 and over, 2017 6 % people aged 65 and over living alone, 2011
Income 7 % of people aged 60 or over living in a household receiving means-tested benefit & low income (pension credits), 2015 8 % people in this area living in 20% most deprived areas in England, 2015 9 % children (under 16) in families receiving means-tested benefits & low income, 2015 10 Average monthly claimants of jobseekers allowance who have been claiming for more than 12 months, rate per 1000 of the working age population (age 16-64 years), 2017/18
Young People 11 Total live births per 1000 females aged 15-44, 2011 – 2015 12 % of live and stillbirths weighing less than 2,500 grams, 2011-15 13 % of delivery episodes, where the mother is aged under 18 years, 2011/12-2015/16 (financial years pooled) 14 A&E attendance for children aged 0-4 years, crude rate per 1,000 resident population, 2013/14-2015/16 (financial years pooled) 15 Hospital admissions following injury in children aged 0-4 years, crude rate per 10,000 resident population, 2011/12-2015/16 (financial years pooled) 16 Emergency hospital admissions for children (aged 0-4 years), crude rate per 1,000 population from 2013/14-2015/16 (financial years pooled) 17 % children achieving a good level of development within Early Years Foundation Stage Profile at the end of the academic year in which they turn 5 by pupil residency, 2013-14 academic year 18 % Pupils achieving 5 or more GCSEs at grades A*-C (including English and Maths) or equivalent end of Key Stage 4 in schools maintained by the Local Authority, 2013-14 academic year 19 % school children measured in reception year (age 4-5) who were classified as overweight or obese, 2015/16-2017/18
20 % school children measured in Year 6 (age 10-11) who were classified as overweight or obese, 2015/16-2017/18
Lifestyle 21 % children aged 11-15 who regularly smoke, Modelled estimates 2009-12 22 % children aged 16-17 who regularly smoke, Modelled estimates 2009-12 23 % adults aged 16 and over that consume 5 or more portions of fruit and vegetables per day, Modelled estimates 2006-08 24 % adults aged 16 and over classified as obese (BMI of 30+), Modelled estimates 2006-08 25 % adults aged 16 and over who binge drink, Modelled estimates 2006-08 26 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, standardised admission ratio, 2013/14-2017/18
Illness 27 % of people who reported their heath as bad or very bad in the 2011 Census 28 % of people who reported their day-to-day activities were limited by ill health or disability, 2011 Census 29 Hospital admissions for intentional self harm, standardised admission ratio, 2013/14-2017/18 30, 31, 32, 34 Emergency admissions, standardised admission ratio, 2013/14-2017/18 33 Emergency hospital admissions for hip fractures, persons aged 65+, standardised admission ratio, 2013/14-2017/18
Cancer 35, 36, 37, 38, 39 Standardised incidence ratio for new cancer diagnoses, 2012-2016
Death 40, 41, 42 Standardised mortality ratio for deaths aged under 75, 2013-2017 43, 44 Standardised mortality ratio for deaths all ages, 2013-2017 45 Female Life Expectancy at birth, 2013-2017 46 Male Life Expectancy at birth, 2013-2017

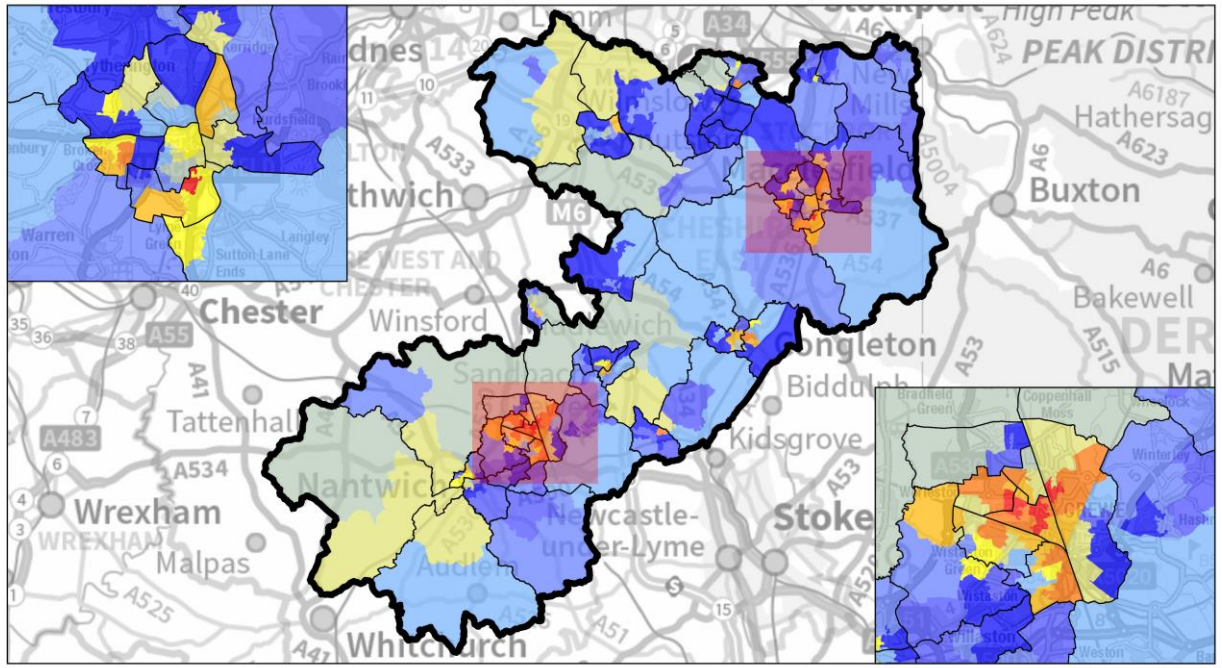
More information and full metadata available www.localhealth.org.uk

Abbreviations
SMASH = Sandbach, Middlewich, Alsager, Scholar Green, Haslington
SAR = Standardised Admissions Ratio
SIR = Standardised Incidence Ratio
SMR = Standardised Mortality Ratio
Ratios are calculated by dividing the observed total number of admissions, new cases or deaths in the area by the expected number and multiplying by 100. Expected numbers are calculated by applying age-sex-specific rates for England in the same time period to each area's population.

A focus on Crewe

#BecauseWeCare
Cheshire East Partnership

Index of Multiple Deprivation 2019 - Overall Deprivation Decile



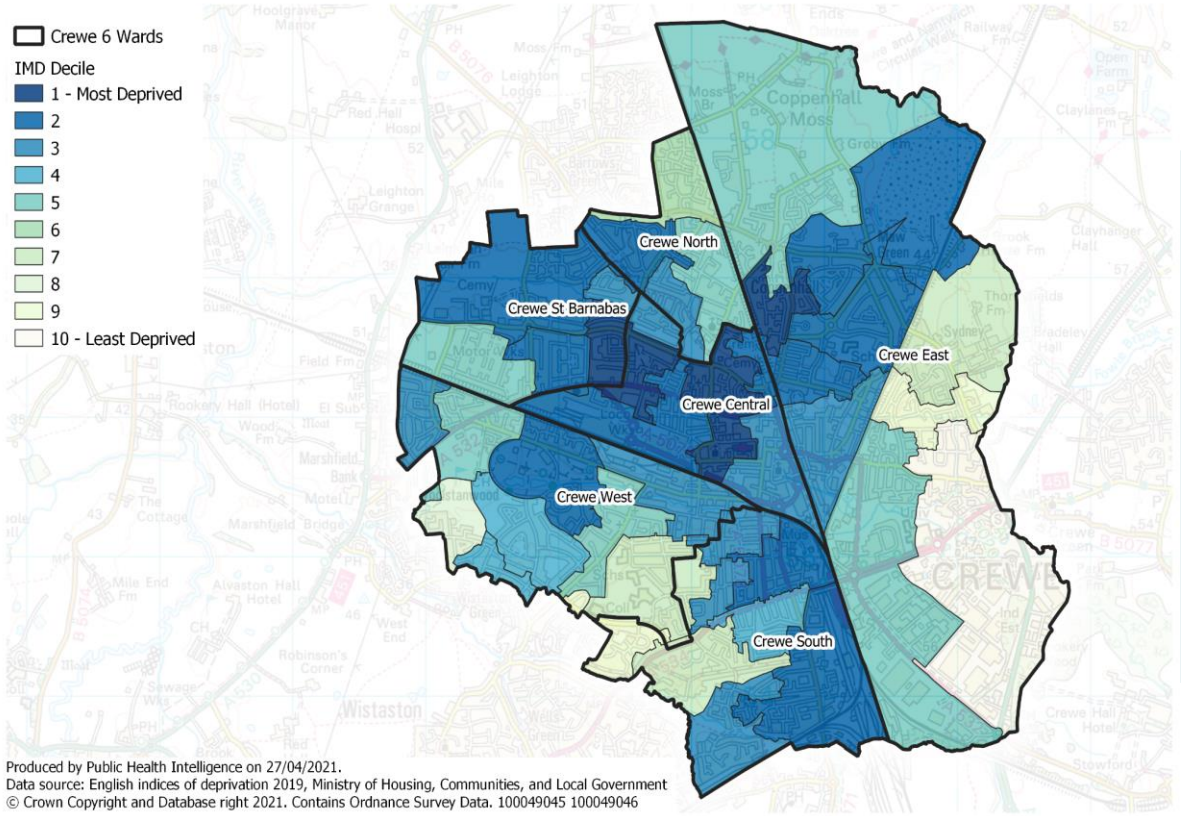
Cheshire East Council

IMD LSOA Decile
1 - Most Deprived
2
3
4
5
6
7
8
9
10 - Least Deprived
Wards

1:325,000

Source: Index of Multiple Deprivtion (IMD), 2019, MHCLG

Crewe 6 Wards showing Index of Multiple Deprivation (IMD) 2019 Decile by LSOA



Produced by Public Health Intelligence on 27/04/2021.
Data source: English indices of deprivation 2019, Ministry of Housing, Communities, and Local Government

Crewe Primary Care Network 1 of 2

#BecauseWeCare
Cheshire East Partnership

Four distinct ‘wants’/business cases

#BecauseWeCare
Cheshire East Partnership

		Service Proposition	What do patients look for?	Attributes	Key success factors	
Fix me!	 Wonderful service! I was back on my feet quickly. Great, courteous and efficient.	• Focused care to ‘fix patient’ following a definitive diagnosis. • Clinical innovation to deliver good outcomes	• Accessibility • To be seen quickly • Reputation for quality • Expert care • Rapid return to normal life • Pleasant environment	• Predictable activity • Minimal variation • Volume based • Higher turnover of patients • Outcome based	• Cost competitiveness • Recruitment and retention • Capacity • Patient journey management	We provide medical and surgical services to treat our patient and deliver optimal outcomes
What’s wrong with me?	 I can really rely on the Trust to help me and provide the care I need.	• Expert diagnostics and pathway co-ordination to provide patients with shortest and most effective route to diagnosis and plan of care	• Access to specialist expertise • Convenience • Predictability • Quick resolution • Customer service	• Collaborative care, single clinical coordination • Centralised with satellite locations e.g. diagnostics • Activity based	• Capacity • Responsiveness • Patient journey management • Specialist equipment and resources	We provide the expertise, access and convenience to diagnose and develop treatment plans for our patients
Help me stay well	 The CARE is always there for me. I do not know how I would cope without them.	• Integrated care network • Services geared to support patients to manage their wellbeing and exacerbations • Patient to patient support networks	• Service fits around their life • Trust and compassion • Availability • Support for self management • Long term relationship	• Distributed and decentralised model • Care coordination hub across primary, community, secondary, tertiary and social care • Outcome based	• Level of integration and co-operation • Multi-skilled resources • Communication and engagement	We provide integrated care and work with carers, patients and their local community to keep them well in an environment that meets their needs.
End of Life	 My father was able to live the last days in comfort and get closure.	• Holistic and personalised care enabling dignified end of life care and support for family and carers	• Empathy • Trusted advice • Approachability • Recommendation • Convenience • Please environment	• Care coordination • Network of services • Distributed service • Heavy personalisation • Flexible	• Personalisation of care • Patient experience management • Continuity of care • Multi-skilled resources	We provide the best possible end of life care

Moving forward, together

#BecauseWeCare
Cheshire East Partnership

Crewe's future growth

Crewe has the borough's:

- largest and fastest-growing population
- youngest population
- most affordable housing
- lowest land values
- greatest need in terms of public health and other indicators

It also has the borough – and wider sub-region's - **greatest opportunity:**

- a strong, successful and growing business base – including Bentley which is delivering a multi-billion investment to manufacture new electric models
- the only town or city in the north of England with a firm commitment for a HS2 hub station – 10 years ahead of Manchester.

It is therefore **uniquely positioned** to benefit from future investment, building on regular high speed services to London and Birmingham, increased network capacity, and:

- The only NW location shortlisted as HQ for Great British Railways
- 3 million people within a 45 minute commute
- Outstanding skills and education infrastructure

A Cheshire East approach

#BecauseWeCare
Cheshire East Partnership

- View strategies and plans through the lens of wants as well as need.
- Develop our partnership.
- Build on strong foundations in primary care.
- Grow our eight Care Communities including Crewe.
- Focus on aligning economic value to health value.

#BecauseWeCare
Cheshire East Partnership

Thank you

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

27 October 2022

Cheshire & Merseyside System Finance Report – Month 6

(September 2022)

Agenda Item No	**ICB/10/22/08**
Report author & contact details	Mark Bakewell – Deputy Director of Finance
Report approved by (sponsoring Director)	Claire Wilson – Executive Director of Finance
Responsible Officer to take actions forward	Claire Wilson – Executive Director of Finance

Cheshire and Merseyside ICB Board Meeting

Cheshire & Merseyside System Finance Report – Month 6

Executive Summary	This report updates the Board on the financial performance of Cheshire and Merseyside ICS ("the System") for 2022/23, in terms of relative position against its financial plan as submitted to NHS England in June 2022, alongside other measures of financial performance (e.g., Cash Management and Better Payment Practice Code) and utilisation of available 'Capital' resources for the financial year.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X				
Recommendation	**The Board is asked to:** • **note** the contents of this report in respect of the Month 6 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year.				
Key risks	Financial risks associated with delivery of financial position set out in the paper				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	X	X	X	X	
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
	X	X	X	X	
Route to this meeting	-				
Next Steps	Continued monitoring of financial forecasts for revenue and capital allocations. Further development of cost improvement plans and system wide efficiency opportunities. Development of financial strategy to support future financial sustainability.				
Appendices	**Appendices 1-7** gives details of the narrative in the main body of the report.				

Cheshire and Merseyside ICB Board Meeting

System Finance Report to 30 September 2022 (Month 6)

1. Executive Summary

1.1 This report updates the ICB on the financial performance of Cheshire and Merseyside ICS ("the System") for 2022/23, in terms of relative position against its financial plan as submitted to NHS England, and alongside other measures of financial performance (e.g., Cash Management and Better Payment Practice Code) and utilisation of available 'Capital' resources for the financial year.

1.2 **M6 Performance – Revenue.** As at 30 September 2022 (Month 6), the ICS 'System' is reporting an aggregate deficit of £55m against a planned deficit of £30.2m resulting in an adverse year to date variance of £24.7m.

1.3 As set out in the table below, this is due to a lower-than-expected year-to-date surplus position of £2.4m for CCGs/ ICB (compared to a plan profile value of £9.8m) and a year-to-date deficit in the NHS providers of £57.4m (compared to plan profile of £40.1m).

Sector	2022/23 Annual Plan £m Surplus / (Deficit)	2022/23 YTD Plan £m Surplus / (Deficit)	2022/23 YTD Actual £m Surplus / (Deficit)	YTD Variance £m Surplus / (Deficit)	2022/23 Forecast £m Surplus / (Deficit)	Forecast Variance £m Surplus / (Deficit)
CCG/ICB	19.7	9.8	2.4	(7.4)	19.7	0.0
NHS Providers Trusts	(50.0)	(40.1)	(57.4)	(17.3)	(49.9)	0.1
Total System	**(30.3)**	**(30.2)**	**(55.0)**	**(24.7)**	**(30.2)**	**0.1**

1.4 The ICB and NHS providers continue to forecast achievement of the annual planned deficit of £30.3m. However, there are a number of risks that will require management as a system to ensure that the plan is delivered.

1.5 **M6 Performance – Capital.** As at 30th September 2022, progress of the system's local operational capital programme expenditure (excluding impact of IRFS16) remains below year to date planned values by £32.6m as described in the main body of the report. However, with regards to the outturn position, current forecasts suggest an overspend position of £8.8m, which is related to additional PDC awarded to Mid Cheshire Hospitals NHS Foundation Trust to address the reinforced aerated autoclave concrete (RAAC) within their buildings. However, the ICS plans have not been updated nationally to reflect this.

1.6 This month the ICS is working closely with the providers to identify realistic forecast to ensure the ICS meets the Capital envelope for 22/23. Information related to IFRS16 leases is being collected this month and will be reported on in month 7.

2. Background

2.1 This report updates the ICB on the financial performance of Cheshire and Merseyside ICS ("the System") for 2022/23, in terms of relative position against its financial plan as submitted to NHS England in June 2022, alongside other measures of financial performance (e.g. Cash Management and Better Payment Practice Code) and utilisation of available 'Capital' resources for the financial year.

2.2 The revised system plan for 2022/23 submitted on 20th June was a combined £30.3m deficit consisted of a £19.7m 'surplus' on the commissioning side (CCG/ ICB) which partly offset an aggregate NHS provider deficit position of £50.0m. The plan position reflected a variety of surplus / deficit positions across each C&M CCG and NHS Provider organisations as can be seen in Appendix 1.

2.3 It should be noted that ICBs as successor bodies to CCGs are required to plan for 'at least' a break-even position as reflected in the recent Health & Social Care Act, which has been reflected in the distribution / relative risk position within the ICS plan submission.

2.4 At the end of quarter one and in all financial performance circumstances, CCGs have been deemed to have delivered a breakeven financial performance position through an adjusting resource allocation process for the Q1 period (from the full year ICB allocation) with any residual difference in Q1 performance (both favourable / adverse) being inherited by the ICB during Q2-4.

2.5 As a result, the additional surplus above plan of £6.7m originally reported by CCGs has been transferred to the ICB.

3. Key movements in month:

3.1 The following resource allocation adjustments have been made to the ICB resource limit in month:

Financial position

- Month 6 YTD system financial performance has worsened by £10m to £55m deficit (YTD plan of £30.2m deficit)
- Unmitigated net risk remains consistent with month 5 at £74m.
- CIP YTD performance has improved by £21m in month to £136.7m (full year plan is £330.9m).

Revenue allocations

- £69.9m pay award/NIC adjustment to fund providers costs relating to pay inflation.
- £13.1m Demand & Capacity – non recurrent funding to support winter capacity
- £4.3m Cancer SDF – funding confirmed for quarter 3
- £3m Transforming Care adjustment
- £2.3m Virtual Ward funding
- £0.9m DOAC rebates relating to 2021/22
- Repayment of £14m surge funding from 2021/22.

4. Month 6 (September) Performance

4.1 **ICB/CCG performance.** For quarter 1, the CCGs allocations were adjusted to a breakeven position to match the reported position, this has resulted in the movement of the £6.7m favourable variance to plan from CCGs budgets to the ICB budget to support achievement of the annual plan.

4.2 The ICB is currently reporting a year-to-date surplus of £2.4m compared to an original planned surplus of £9.8m (when adjusted for the original) resulting in an adverse variance to plan of £7.4m as per the below table.

	2022/23 YTD Plan £m Surplus / (Deficit)	2022/23 YTD Actual £m Surplus / (Deficit)	2022/23 YTD Variance £m Surplus / (Deficit)	2022/23 YTD % Variance £m Surplus / (Deficit)
System Revenue Resource Limit	**-1,488,365**			
ICB Net Expenditure				
Acute Services	797,405	797,227	178	0.0%
Mental Health Services	141,860	144,616	(2,756)	(1.9%)
Community Health Services	154,302	155,781	(1,479)	(1.0%)
Continuing Care Services	70,601	71,955	(1,355)	(1.9%)
Primary Care Services	152,129	149,574	2,555	1.7%
Other Commissioned Services	3,932	3,889	43	1.1%
Other Programme Services	15,217	15,671	(454)	(3.0%)
Reserves / Contingencies	(9,279)	2,253	(11,532)	124.3%
Delegated Primary Care Commissioning including:	133,852	133,268	584	0.4%
a) Primary Medical Services	116,729	114,781	1,948	1.7%
b) Pharmacy Services	17,123	18,487	(1,363)	(8.0%)
ICB Running Costs	11,797	11,712	84	0.7%
Total ICB Net Expenditure	**1,471,815**	**1,485,945**	**(14,131)**	**(0.9%)**
TOTAL ICB Surplus/(Deficit)	**16,551**	**2,420**	**(14,131)**	(0.9%)
**** NB - CCG Q1 Adjustment***	***(6,716)***		***6,716***	
Adjusted Surplus	***9,835***	***2,420***	***(7,415)***	

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

- Mental Health - increased volume and value of packages of care, including out of area placements and non-contracted activity.
- Primary Care Services - current underspend on prescribing and GPIT but this is not expected to continue to the end of the year.
- Community Services – overspend relating to independent sector contracts, Intermediate care and reablement.
- Continuing care - Overspend relating to increases to volume and price for continuing care packages and funded nursing care.

- Reserves – due to accepted planning risks as outlined below with mitigations being developed with partners and place teams.
- Primary Care Delegated budgets – overspend areas include enhanced services, estates and other local discretionary expenditure.
- Delegated Pharmacy pressures (ICB responsibility from 1st July 2022) pressures being managed with NHS I/E
- Efficiency savings are built into the year-to-date position and reflects a favourable position of £2.8m but a significant proportion of this is non-recurrently delivered. Development of recurrent savings is a key area of focus. Further detail is provided in the sections below.

4.4 Further work is required to review transactions from predecessor organisations to ensure a consistency of approach to accounting policies e.g the basis for accruals in areas such as prescribing.

4.5 The ICB continues to forecast achievement of the annual planned surplus of £19.7m. However, there are several risks that are being actively managed to ensure the plan is delivered. This includes a step change in the focus on the development of recurrent efficiencies.

4.6 Analysis has been undertaken at place level to understand the drivers for the adverse variance and emerging risks. Recovery plans have now been received from Wirral, Cheshire East and Cheshire West and are currently being reviewed.

4.7 **NHS Provider Performance.** The table below summarises the combined NHS provider position to the end of September 2022 reflecting a year-to-date cumulative deficit position of £57.4m compared to a year-to-date profile plan figure of £40.1m. Further detail is provided in Appendix 2.

	M6 YTD Plan £m	M6 YTD Actual £m	M6 YTD Variance £m	Annual Plan £m	M6 Forecast ACTUAL £m	M6 Forecast VARIANCE £m
Alder Hey Children's NHS Foundation Trust	(1.5)	(1.5)	0.0	4.6	4.6	(0.0)
Bridgewater Community Healthcare NHS Foundation Trust	(0.2)	(0.2)	0.0	0.0	0.0	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	1.2	1.3	0.0	2.9	2.9	0.0
Countess of Chester Hospital NHS Foundation Trust	(4.2)	(12.4)	(8.2)	(3.1)	(3.1)	0.0
East Cheshire NHS Trust	(2.2)	(2.1)	0.0	(2.6)	(2.6)	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	1.2	1.7	0.5	2.3	2.3	(0.0)
Liverpool University Hospitals NHS Foundation Trust	(15.2)	(20.5)	(5.3)	(30.0)	(30.1)	(0.1)
Liverpool Women's NHS Foundation Trust	0.8	0.8	0.0	0.6	0.6	0.0
Mersey Care NHS Foundation Trust	2.3	2.3	0.0	5.7	5.7	0.0
Mid Cheshire Hospitals NHS Foundation Trust	(6.7)	(7.7)	(1.1)	(10.4)	(10.4)	(0.0)
Southport And Ormskirk Hospital NHS Trust	(9.5)	(9.5)	0.0	(14.2)	(14.2)	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	(2.2)	(2.2)	0.0	(4.9)	(4.9)	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	0.8	1.4	0.6	1.6	1.6	(0.0)
The Walton Centre NHS Foundation Trust	1.1	1.3	0.2	2.9	3.1	0.2
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(7.3)	(7.5)	(0.2)	(6.1)	(6.1)	0.0
Wirral Community Health and Care NHS Foundation Trust	0.4	0.4	0.0	0.7	0.7	0.0
Wirral University Teaching Hospital NHS Foundation Trust	1.0	(3.1)	(4.0)	0.0	0.0	0.0
Total Providers	**(40.1)**	**(57.4)**	**(17.3)**	**(50.0)**	**(49.9)**	**0.1**

4.8 Five provider Trusts continue an adverse year to date deficit position for months 1-6, resulting in an adverse position compared to plan of £18.8m.

4.9 Although providers continue to forecast achievement of the annual planned £50m deficit, several risks will require management as a system to ensure delivery of the plan, which are explained further below. Key pressures relate to underachievement on delivery of planned cost improvement programmes, rising inflation with regard to energy and operational pressures associated with continued provision of escalation bed capacity.

4.10 National guidance is due to be published on the requirements that must be met before any organisation can declare a forecast position adverse to plan and the ICS team are working with providers to understand the implications of this and monitoring the unmitigated risk position closely.

4.11 Further analysis of the year-to-date position demonstrates that the adverse position is a result of higher than anticipated pay costs (£104m) offset set by favourable movements in Income (£91.7m) and non-operating expenditure (£3.5m) as per the table below.

Surplus / (Deficit)	2022/23 Year-to-date				2022/23 Forecast			
	Plan	Actual	Under/(over) spend		Plan	Actual	Under/(over) spend	
	£m	£m	£m	%	£m	£m	£m	%
Income excluding COVID Reimbursements	2,794.7	2,885.5	90.8	3.2%	5,596.0	5,721.1	125.1	2.2%
COVID-19 Reimbursements	6.0	7.0	0.9	15.0%	10.7	12.2	1.5	14.0%
Total Income	2,800.7	2,892.5	91.7	3.3%	5,606.7	5,733.3	126.6	2.3%
Pay	(1,815.9)	(1,919.9)	(104.0)	5.7%	(3,632.8)	(3,774.0)	(141.2)	3.9%
Non Pay	(976.3)	(984.8)	(8.5)	0.9%	(1,926.7)	(1,917.8)	8.9	(0.5%)
Non Operating Items (exc gains on disposal)	(48.7)	(45.2)	3.5	(7.2%)	(97.2)	(91.4)	5.8	(6.0%)
Total Expenditure	(2,840.9)	(2,949.9)	(109.0)	3.8%	(5,656.7)	(5,783.2)	(126.5)	2.2%
C&M NHS Providers	**(40.2)**	**(57.4)**	**(17.3)**	**0.6%**	**(50.0)**	**(49.9)**	**0.1**	**(0.0%)**

4.12 The following Trusts are currently reporting adverse variances to plan in the year to date. The ICB Executive team, together with peer CEOs, are meeting regularity with each trust to discuss the drivers of the positions reported and to seek assurance of the work being done to support delivery of the financial plan whilst delivering safe, high-quality care for our resident population. Most Trusts are raising concerns around energy inflation, with the exact detail of government support still to be defined.

- **Countess of Chester NHS Foundation Trust.** Variance to plan driven by significant increases in agency staff, particularly nursing, as well as not achieving agreed cost improvement targets. The Trust has also invested in support to address quality improvements. Delivery of forecast financial plan remains a key risk.

- **Liverpool University Hospitals NHS Foundation Trust (LUFT).** The adverse YTD position is driven by under delivery of CIP programme, escalation beds open across both sites, reflecting high demand and high numbers of patients with no criteria to reside. The Trust is heavily reliant on agency and bank support to meet capacity. Productivity remains behind pre-pandemic levels.

An external financial review has been undertaken to support the Trust in its wider improvement programme, identifying the drivers of the deficit and reviewing the underlying financial position. The Trust is developing a financial strategy to address the longer-term drivers of the deficit with the support of system partners. While the Trust is forecasting to meet plan, this remains a key risk.

- **Mid Cheshire NHS Foundation Trust (MCHFT).** The Trust is experiencing increased unplanned demand, resulting in corridor care, premium costs associated with agency nursing, and additional escalation beds. These additional costs are causing the variance to plan YTD.

- **Warrington & Halton Teaching Hospitals NHS Foundation Trust (WHH).** Small adverse variance to plan as a result of continuation of escalation bed capacity originally planned to be closed. The Trust's CIP programme is significantly back-profiled raising concerns regarding delivery throughout the remaining 6 months of the year.

- **Wirral University Teaching Hospitals NHS Foundation Trust.** The Trust set an ambitious plan to deliver a breakeven position for the year. The adverse variance to plan is as a result of escalation beds, the continued use of corridor care in ED, increased energy costs and the Trust's underperformance in respect of recurrent CIP.

4.13 **Provider Agency Costs.** ICB Providers set a plan for agency spend of £113.307m, compared to actual spend in 21/22 of £139.180m. The system is required to manage agency costs within budget and to demonstrate reduced reliance on agency staffing year on year. Agency spend is being closely monitored with approval required from NHS England for all non-clinical agency above £50k. In Month 6, agency spend is £20.9m above plan, with all Trusts except for Southport and Ormskirk and Mid Cheshire reporting adverse to plan. The current forecast is £12.9m above plan. See appendix 3 for detail by Provider.

5. Efficiencies

5.1 **ICB Efficiencies.** The ICB is currently reporting a £2.8m favourable variance to plan YTD as a result of non-recurrent benefits released by CCGs in Q1. The ICB is currently forecasting to achieve the planned efficiencies of £68.8m. However, there remains a level of unidentified efficiency as highlighted below that requires identification in order to deliver the plan.

5.2 The ICB has established a programme approach to identification, development and tracking of efficiencies and this is a key focus of the corporate executive team and Place Directors. Detailed reports will be developed for future reporting periods to allow the Board and Finance, Resources and Investment Committee to seek further assurance on delivery of the recurrent target.

5.3 **Provider Efficiencies.** Provider efficiency schemes are £14.0m behind plan at month 6, efficiencies of £99.5m have been delivered to date compared to a plan of £113.5m. However, only £37.7m of this has been delivered recurrently (£61.8m non-recurrently) and this is a key risk to the underlying financial position of the system. The detail by provider is included in Appendix 4.

6. Risks & Mitigations

6.1 **ICB Risks & Mitigations.** Following review of the month 6 financial position a number of risks are emerging that will require actions to mitigate during the year in order for the ICB to achieve the planned surplus of £19.7m.

6.2 A recent ICB financial planning risk review has identified a current potential of £62.3m of 22/23 financial year risks with a series of potential mitigations assessed at a value of £46.9m leaving a residual unmitigated risk of £15.4m. Key risks are included in the table below:

Risk	Gross Risk £m	Residual Risk after Mitigations £m
Drawdown funding not received	-7.7	-7.7
Delegated Pharmacy over performance	-3.4	0
Additional System Efficiencies	-16.1	-3.5
ICB Additional Efficiencies/Operational Pressures	-35.1	-4.2
Total ICB	**-62.3**	**-15.4**

6.3 The ICB is working alongside system partners to ensure mitigation plans are in place to manage risks including the following:

- follow up with NHSE national team regarding the recent withdrawal of previously approved drawdown funding (and previously agreed with CCGs as part of 2:1 agreements in 2019/20) and understanding of consequential impact.
- further discussions with NHSE regional team regarding the over performance in Delegated Pharmacy transferred to the ICB on the 1st July 2022.
- agreement of recovery plans for 'places' currently off track to plan (Wirral, East and West Cheshire).
- review of ICB expenditure budgets including SDF and HCP programmes.

6.4 **Provider Risks & Mitigations.** NHS England collect gross risk data from each provider, together with the mitigations currently being managed. A net risk position is then calculated for each system.

6.5 For Cheshire and Merseyside, £199.9m of gross risk is being reported across providers, with mitigations being pursued for £141.7m of this, leaving a net risk position of 58.2m. Non delivery of CIP, energy inflation, and pay pressures are being flagged as the main risks at month 6. However, some energy risks will be further mitigated with the recent policy announcement on energy price caps. This net risk is not reflected in forecast positions, with all Trusts continuing to report in line with plan at this stage but there are active discussions with a small number of providers where the risk of being unable to deliver in line with plan is becoming more likely.

7. Other Performance Indicators

7.1 Cash – ICB. The ICB is expected to manage its cash balances during the year so that the closing cash balance at bank should be no greater than either 1.25% of the monthly drawdown or £250k, whichever is greater.

7.2 The cash balance for the ICB at the end of September was £28.8m which equates to 6% of the cash drawdown for September. This was higher than planned, but partly reflects further requirements to understand the cash patterns of the new organisation, budget holder responsibilities and workflow arrangements to clear invoices that were unable to be paid during the cutover period in July in order to ensure the ICB remains within the recommended balances.

7.3 **C&M NHS Providers.** From a provider perspective total cash levels as detailed in Appendix 5 have reduced by 16% from the level at the end of the 2022/23 financial year. Aggregate provider balances as at month 6 were £736.8m, compared with £912.1m at the end of 2021/22.

7.4 Liverpool Women's NHS Foundation Trust, Mid Cheshire Hospitals NHS Foundation Trust, Southport and Ormskirk NHS Trust have indicated some concerns regarding managing their cash balances. Re-profiling of contract payments is being utilised to support Southport and Ormskirk's cash position to support them to year-end.

7.5 During quarter 3 further analysis will be undertaken in conjunction with NHSE of providers' balance sheets.

7.6 **Better Payment Practice Code.** The ICB Better Payment Practice Code performance by value at the end of September was:

- 100% of invoices to NHS suppliers and 88% of invoices to NHS suppliers by value were paid on time.
- performance by volume was 90% for NHS suppliers and 93% for Non NHS suppliers.

7.7 The target for both measures is 95% and therefore unfortunately the Better Payments Practice Code (BPPC) target was not fully met but again reflects the challenges of emerging over the transition period.

7.8 A number of factors have affected the ICBs ability to meet the target to date including the setting up of the new ICB financial system and linked transfer of all legacy invoices from CCG ledgers (during the first 3 weeks of July by SBS) with subsequent coding and approval of this significant volume of invoices causing delays to payments and therefore performance measures have not been met. Improving this position will be a key area of focus for the finance team over coming weeks.

7.9 **C&M NHS Providers.** For providers as set out in the table included in Appendix 6, only 3 providers are currently meeting the targets for invoice payment by both value and number measures within the 95% target.

7.10 Prompt settlements of invoices to small private and charitable sector suppliers is regarded as critical, particularly considering the current economic landscape.

7.11 **Capital.** The 'Charge against Capital Allocation' represents the System's performance against its operational capital allocation, which is wholly managed at the System's discretion. Spend in relation to National programmes and other items chargeable to the Capital Direct Expenditure Limit (CDEL) are effectively administered on the behalf of systems, and therefore under/overspending does not score against System's Capital performance.

7.12 As per the table below, at month 6, progress of the system's operational capital programme expenditure (excluding IFRS 16 impact) remains below year-to-date planned values by £32.6m. Given increasing lead times for equipment and rising construction costs the position will be reviewed alongside providers this month in order to identify a realistic forecast and actions to be taken to secure spend within the allocated envelope.

7.13 Currently the system is forecasting to overspend against its plan by £8.9m. This £8.9m overspend is related to an approved PDC-funded RAAC business cases, where the allocation has been updated, but not the ICB plans. The 2022/23 plan included a 5% overspent, equating to £12m, which needs to be managed in year.

7.14 Work is progressing to confirm realistic forecasts for each Provider to ensure the ICB meets the system envelope of £221m.

7.15 **Primary Care Capital.** C&M ICB has a capital allocation of £4.7m for Primary Care, but also benefits this year from a legal charge redemption of £1.235m.

7.16 NHSE Primary Care commissioners have engaged with GP practices and premises grant requests totaling £1.826m in 22/23 with a further 23/24 impact of £0.846m have been received and reviewed against the requirements of the Premises Directions. Plans have now been approved by the ICB Primary Care Committee and NHSE.

7.17 In addition, the C&M digital lead is developing proposals for GPIT.

7.18 **Strategic Capital.** There are a large number of Strategic Capital schemes, administered by NHS England, the main ones being:

- Mental Health – Urgent and Emergency Care, Dorm Eradication.
- Elective Targeted Investment Fund.
- Community Diagnostic Centres.
- Diagnostics – Levelling up, digitisation, single CT scanner sites.
- Digital – EPR, frontline digitisation.
- NHP – New Hospitals Programme.

7.19 Business cases to bid for these funds have been submitted and the vast majority of funds allocated for Mental Health, TIF, CDC, NHP and Diagnostics. Digital Diagnostics and Frontline digitisation are yet to be allocated.

7.20 The revenue consequences of these investments may pose a risk to providers financial positions should anticipated efficiencies not be delivered.

7.21 Performance against these schemes does not score against the System allocation, but slippage on these schemes can adversely impact the system allocation in future years.

8. Recommendations

8.1 **The Integrated Care Board is asked to:**

- Note the contents of this report in respect of the month 6 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year.

Officer contact details for more information

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Appendix 1

2022/23 plan submissions by CCG / NHS provider

CCG / ICB	Full Year Plan (Deficit) / Surplus
	£ 000's
NHS HALTON CCG	(3,340)
NHS KNOWSLEY CCG	12,051
NHS SOUTH SEFTON CCG	(4,051)
NHS SOUTHPORT AND FORMBY CCG	(6,336)
NHS ST HELENS CCG	(1,905)
NHS WARRINGTON CCG	(2,302)
NHS WIRRAL CCG	7,499
NHS CHESHIRE CCG	(27,663)
NHS LIVERPOOL CCG	18,259
Total CCG Position	(7,788)
NHS LIVERPOOL CCG - as ICB Host	27,802
Total ICB Planned (Deficit/Surplus)	**20,014**

Cheshire & Merseyside Provider Organisation	Full Year Surplus / (Deficit) £'000s
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	4,630
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	0
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	2,856
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	(3,066)
EAST CHESHIRE NHS TRUST	(2,554)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	2,328
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	(30,010)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	563
MERSEY CARE NHS FOUNDATION TRUST	5,698
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	(10,415)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	(14,175)
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	(4,949)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	1,621
THE WALTON CENTRE NHS FOUNDATION TRUST	2,868
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	(6,106)
WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	684
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	19
TOTAL	**(50,008)**

Appendix 2

System Financial Position: Combined Year-to-date Financial Position by Organisation as at Month 5 (30th September 2022)

	M6 YTD Plan £m	M6 YTD Actual £m	M6 YTD Variance £m	Annual Plan £m	M6 Forecast ACTUAL £m	M6 Forecast VARIANCE £m
CCGs/ICB	9.8	2.4	(7.4)	19.7	19.7	0.0
	9.8	**2.4**	**(7.4)**	**19.7**	**19.7**	**0.0**
Providers:						
Alder Hey Children's NHS Foundation Trust	(1.5)	(1.5)	0.0	4.6	4.6	(0.0)
Bridgewater Community Healthcare NHS Foundation Trust	(0.2)	(0.2)	0.0	0.0	0.0	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	1.2	1.3	0.0	2.9	2.9	0.0
Countess of Chester Hospital NHS Foundation Trust	(4.2)	(12.4)	(8.2)	(3.1)	(3.1)	0.0
East Cheshire NHS Trust	(2.2)	(2.1)	0.0	(2.6)	(2.6)	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	1.2	1.7	0.5	2.3	2.3	(0.0)
Liverpool University Hospitals NHS Foundation Trust	(15.2)	(20.5)	(5.3)	(30.0)	(30.1)	(0.1)
Liverpool Women's NHS Foundation Trust	0.8	0.8	0.0	0.6	0.6	0.0
Mersey Care NHS Foundation Trust	2.3	2.3	0.0	5.7	5.7	0.0
Mid Cheshire Hospitals NHS Foundation Trust	(6.7)	(7.7)	(1.1)	(10.4)	(10.4)	(0.0)
Southport And Ormskirk Hospital NHS Trust	(9.5)	(9.5)	0.0	(14.2)	(14.2)	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	(2.2)	(2.2)	0.0	(4.9)	(4.9)	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	0.8	1.4	0.6	1.6	1.6	(0.0)
The Walton Centre NHS Foundation Trust	1.1	1.3	0.2	2.9	3.1	0.2
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(7.3)	(7.5)	(0.2)	(6.1)	(6.1)	0.0
Wirral Community Health and Care NHS Foundation Trust	0.4	0.4	0.0	0.7	0.7	0.0
Wirral University Teaching Hospital NHS Foundation Trust	1.0	(3.1)	(4.0)	0.0	0.0	0.0
Total Providers	**(40.1)**	**(57.4)**	**(17.3)**	**(50.0)**	**(49.9)**	**0.1**
Total System	**(30.2)**	**(55.0)**	**(24.7)**	**(30.3)**	**(30.2)**	**0.1**

Note: brackets denote deficit/overspend.

Appendix 3

Agency spend: Current Performance and Forecast Outturn as at Month 6 (30th September 2022)

PROVIDER:	Month 6 YTD			Month 12 Forecast		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m
Alder Hey Children's NHS Foundation Trust	0.0	0.8	0.8	0.0	0.8	0.8
Bridgewater Community Healthcare NHS Foundation Trust	2.5	3.0	0.5	5.0	6.1	1.2
Cheshire and Wirral Partnership NHS Foundation Trust	1.5	3.6	2.0	3.1	6.0	2.9
Countess of Chester Hospital NHS Foundation Trust	4.2	9.4	5.2	8.4	10.5	2.0
East Cheshire NHS Trust	3.6	4.9	1.3	7.7	7.7	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	0.3	0.6	0.3	0.7	1.1	0.4
Liverpool University Hospitals NHS Foundation Trust	6.1	8.7	2.6	12.2	16.9	4.7
Liverpool Women's NHS Foundation Trust	0.4	1.7	1.3	0.8	1.7	0.9
Mersey Care NHS Foundation Trust	8.9	9.0	0.1	17.7	17.7	0.0
Mid Cheshire Hospitals NHS Foundation Trust	10.5	10.2	(0.3)	21.0	19.1	(1.9)
Southport And Ormskirk Hospital NHS Trust	4.7	3.5	(1.2)	9.4	6.9	(2.5)
St Helens And Knowsley Teaching Hospitals NHS Trust	5.1	6.2	1.1	10.2	10.3	0.1
The Clatterbridge Cancer Centre NHS Foundation Trust	0.0	0.8	0.8	0.0	1.5	1.5
The Walton Centre NHS Foundation Trust	0.0	0.1	0.1	0.0	0.2	0.2
Warrington and Halton Teaching Hospitals NHS Foundation Trust	5.1	7.5	2.5	10.2	10.2	0.0
Wirral Community Health and Care NHS Foundation Trust	0.9	1.3	0.4	1.7	2.1	0.4
Wirral University Teaching Hospital NHS Foundation Trust	1.7	5.2	3.4	5.0	7.4	2.4
Total Providers	**55.5**	**76.4**	**20.9**	**113.3**	**126.2**	**12.9**

Appendix 4

System Efficiencies: Current Performance and Forecast Outturn as at Month 6 (30th September 2022)

	M6 YTD Plan £m	M6 YTD Actual £m	M6 YTD Variance £m	Annual Plan £m	M6 Forecast ACTUAL £m	M6 Forecast VARIANCE £m
CCGs/ICB	34.4	37.2	2.8	68.8	68.8	0.0
	34.4	**37.2**	**2.8**	**68.8**	**68.8**	**0.0**
Providers:						
Alder Hey Children's NHS Foundation Trust	6.0	5.5	(0.6)	14.5	13.4	(1.1)
Bridgewater Community Healthcare NHS Foundation Trust	1.8	1.8	0.0	4.2	4.2	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	4.0	3.5	(0.5)	8.3	8.3	0.0
Countess of Chester Hospital NHS Foundation Trust	4.5	4.4	(0.1)	13.4	13.4	0.0
East Cheshire NHS Trust	2.1	2.2	0.0	5.5	5.5	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	2.4	1.3	(1.1)	4.9	4.9	0.0
Liverpool University Hospitals NHS Foundation Trust	32.7	26.4	(6.3)	75.0	75.0	0.0
Liverpool Women's NHS Foundation Trust	2.8	3.5	0.7	5.6	6.5	0.9
Mersey Care NHS Foundation Trust	11.4	11.4	(0.0)	22.8	22.8	0.0
Mid Cheshire Hospitals NHS Foundation Trust	8.4	8.1	(0.3)	16.8	16.8	0.0
Southport And Ormskirk Hospital NHS Trust	3.9	3.9	0.0	10.8	10.8	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	10.5	10.5	0.0	28.1	28.1	(0.0)
The Clatterbridge Cancer Centre NHS Foundation Trust	3.4	2.6	(0.8)	6.8	6.8	(0.0)
The Walton Centre NHS Foundation Trust	2.1	2.2	0.1	4.9	4.9	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	5.1	5.2	0.1	15.7	15.7	0.0
Wirral Community Health and Care NHS Foundation Trust	2.1	1.7	(0.3)	4.1	4.1	0.0
Wirral University Teaching Hospital NHS Foundation Trust	10.4	5.4	(5.0)	20.8	20.8	0.0
Total Providers	**113.5**	**99.5**	**(14.0)**	**262.2**	**262.0**	**(0.2)**
Total System	**147.9**	**136.7**	**(11.2)**	**330.9**	**330.8**	**(0.2)**

Recurrent/Non-recurrent split of Provider CIP delivery

PROVIDERS	Recurrent				Non Recurrent				TOTAL			
	M6 YTD Actual £m	M6 YTD Variance £m	Forecast ACTUAL £m	Forecast VARIANCE £m	M6 YTD Actual £m	M6 YTD Variance £m	Forecast ACTUAL £m	Forecast VARIANCE £m	M6 YTD Actual £m	M6 YTD Variance £m	Forecast ACTUAL £m	Forecast VARIANCE £m
Alder Hey Children's NHS Foundation Trust	1.6	(2.0)	3.7	(6.1)	3.8	1.5	9.8	5.0	5.5	(0.6)	13.4	(1.1)
Bridgewater Community Healthcare NHS Foundation Trust	0.7	(0.2)	1.9	0.1	1.2	0.2	2.3	(0.1)	1.8	0.0	4.2	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	1.2	0.3	2.7	0.0	2.3	(0.7)	5.6	0.0	3.5	(0.5)	8.3	0.0
Countess of Chester Hospital NHS Foundation Trust	2.1	0.3	5.5	0.0	2.2	(0.4)	7.9	0.0	4.4	(0.1)	13.4	0.0
East Cheshire NHS Trust	0.1	(1.4)	1.6	(1.9)	2.1	1.5	3.9	1.9	2.2	0.0	5.5	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	0.8	(1.1)	3.7	(0.1)	0.5	0.0	1.2	0.1	1.3	(1.1)	4.9	0.0
Liverpool University Hospitals NHS Foundation Trust	6.0	(8.8)	19.5	(12.5)	20.3	2.5	55.5	12.5	26.4	(6.3)	75.0	0.0
Liverpool Women's NHS Foundation Trust	1.4	(0.4)	3.6	(0.6)	2.1	1.2	2.9	1.5	3.5	0.7	6.5	0.9
Mersey Care NHS Foundation Trust	7.6	(0.2)	15.6	0.0	3.7	0.1	7.2	0.0	11.4	(0.0)	22.8	0.0
Mid Cheshire Hospitals NHS Foundation Trust	1.1	(1.8)	6.2	(0.9)	6.9	1.5	10.6	0.9	8.1	(0.3)	16.8	0.0
Southport And Ormskirk Hospital NHS Trust	3.9	0.0	10.8	0.0	0.0	0.0	0.0	0.0	3.9	0.0	10.8	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	5.9	(4.6)	22.1	0.0	4.6	4.6	6.0	(0.0)	10.5	0.0	28.1	(0.0)
The Clatterbridge Cancer Centre NHS Foundation Trust	0.7	(1.5)	2.4	(2.0)	1.9	0.7	4.3	2.0	2.6	(0.8)	6.8	0.0
The Walton Centre NHS Foundation Trust	1.0	(0.6)	2.6	(1.5)	1.2	0.7	2.3	1.5	2.2	0.1	4.9	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	0.9	(1.1)	6.5	0.0	4.3	1.2	9.2	0.0	5.2	0.1	15.7	0.0
Wirral Community Health and Care NHS Foundation Trust	0.8	(0.5)	2.4	(0.3)	0.9	0.2	1.7	0.3	1.7	(0.3)	4.1	0.0
Wirral University Teaching Hospital NHS Foundation Trust	1.9	(5.1)	13.8	0.0	3.6	0.1	7.0	(0.0)	5.4	(5.0)	20.8	0.0
Total Providers	**37.7**	**(28.7)**	**124.7**	**(25.8)**	**61.8**	**14.7**	**137.3**	**25.6**	**99.5**	**(14.0)**	**262.0**	**(0.2)**

Appendix 5

Provider Cash: Cash balances as at Month 6 (30th September 2022)

PROVIDER:	MONTH 6 ACTUAL £m	31/03/2022 BALANCE £m	% INCREASE/ DECREASE TO MONTH 12 £m
Alder Hey Children's NHS Foundation Trust	83.5	91.5	(8.7%)
Bridgewater Community Healthcare NHS Foundation Trust	24.2	26.2	(7.6%)
Cheshire and Wirral Partnership NHS Foundation Trust	38.5	41.1	(6.2%)
Countess of Chester Hospital NHS Foundation Trust	35.6	40.9	(12.9%)
East Cheshire NHS Trust	40.3	37.3	8.2%
Liverpool Heart and Chest Hospital NHS Foundation Trust	42.5	42.7	(0.6%)
Liverpool University Hospitals NHS Foundation Trust	126.2	211.4	(40.3%)
Liverpool Women's NHS Foundation Trust	3.3	11.2	(71.0%)
Mersey Care NHS Foundation Trust	104.2	84.2	23.8%
Mid Cheshire Hospitals NHS Foundation Trust	22.0	26.7	(17.6%)
Southport And Ormskirk Hospital NHS Trust	5.4	18.5	(71.0%)
St Helens And Knowsley Teaching Hospitals NHS Trust	41.0	54.2	(24.3%)
The Clatterbridge Cancer Centre NHS Foundation Trust	77.1	80.7	(4.5%)
The Walton Centre NHS Foundation Trust	39.6	40.7	(2.8%)
Warrington and Halton Teaching Hospitals NHS Foundation Trust	37.0	44.7	(17.1%)
Wirral Community Health and Care NHS Foundation Trust	18.4	23.8	(22.8%)
Wirral University Teaching Hospital NHS Foundation Trust	25.0	36.4	(31.4%)
Total Providers	**763.8**	**912.1**	**-16%**

Appendix 6

Provider BPPC: Performance against BPPC targets as at Month 6 (30th September 2022)

Providers	Month 6 22/23			
	BPPC	BPPC	BPPC	BPPC
	NHS - By Value	NHS - By Number	Non NHS - By Value	Non NHS - By Number
Alder Hey Children's NHS Foundation Trust	62.7%	66.0%	86.1%	81.4%
Bridgewater Community Healthcare NHS Foundation Trust	100.0%	99.1%	95.4%	99.5%
Cheshire and Wirral Partnership NHS Foundation Trust	86.9%	81.2%	91.0%	94.1%
Countess of Chester Hospital NHS Foundation Trust	93.7%	85.0%	89.5%	89.7%
East Cheshire NHS Trust	99.3%	94.1%	95.0%	95.1%
Liverpool Heart and Chest Hospital NHS Foundation Trust	99.6%	96.1%	98.6%	96.6%
Liverpool University Hospitals NHS Foundation Trust	97.3%	85.4%	93.2%	90.1%
Liverpool Women's NHS Foundation Trust	83.6%	40.9%	83.3%	78.4%
Mersey Care NHS Foundation Trust	94.2%	94.7%	93.5%	95.2%
Mid Cheshire Hospitals NHS Foundation Trust	95.6%	69.6%	91.8%	91.0%
Southport And Ormskirk Hospital NHS Trust	95.4%	82.3%	95.6%	90.8%
St Helens And Knowsley Teaching Hospitals NHS Trust	90.3%	97.4%	97.1%	96.0%
The Clatterbridge Cancer Centre NHS Foundation Trust	98.2%	98.5%	99.3%	98.0%
The Walton Centre NHS Foundation Trust	71.3%	58.4%	89.0%	88.5%
Warrington and Halton Teaching Hospitals NHS Foundation Trust	82.0%	78.1%	92.6%	92.4%
Wirral Community Health and Care NHS Foundation Trust	82.6%	89.4%	92.7%	90.6%
Wirral University Teaching Hospital NHS Foundation Trust	95.3%	90.4%	95.0%	95.3%

Appendix 7

Provider Capital: Current Performance and Forecast Outturn as at Month 6 (30th September 2022)

(based on formal reporting to NHSEI)

PROVIDER:	M6 YTD PLAN £m	M6 YTD ACTUAL £m	M6 YTD VARIANCE £m	ANNUAL PLAN £m	M6 FORECAST ACTUAL £m	M6 FORECAST VARIANCE £m
Alder Hey Children's NHS Foundation Trust	2.4	2.7	(0.2)	8.9	8.9	0.0
Bridgewater Community Healthcare NHS Foundation Trust	1.5	0.2	1.3	13.9	9.9	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	1.6	1.0	0.7	0.0	0.0	0.0
Countess of Chester Hospital NHS Foundation Trust	5.1	4.9	0.2	0.0	0.0	0.0
East Cheshire NHS Trust	3.1	0.6	2.4	2.1	2.1	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	3.9	3.1	0.9	2.1	2.1	0.0
Liverpool University Hospitals NHS Foundation Trust	26.9	15.2	11.7	0.0	0.0	0.0
Liverpool Women's NHS Foundation Trust	6.5	2.9	3.7	0.0	0.0	0.0
Mersey Care NHS Foundation Trust	3.6	0.9	2.6	2.6	2.6	0.1
Mid Cheshire Hospitals NHS Foundation Trust	11.8	9.7	2.1	2.6	2.6	(8.9)
Southport And Ormskirk Hospital NHS Trust	3.3	3.4	(0.1)	0.0	0.0	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	2.9	1.1	1.8	0.0	0.0	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	3.5	0.6	2.9	19.9	19.9	(0.0)
The Walton Centre NHS Foundation Trust	2.8	1.1	1.6	20.3	20.4	0.0
Warrington and Halton Teaching Hospitals NHS Foundation	4.2	3.8	0.4	0.0	0.0	0.0
Wirral Community Health and Care NHS Foundation Trust	4.0	3.0	1.0	0.0	0.0	0.0
Wirral University Teaching Hospital NHS Foundation Trust	5.5	6.0	(0.5)	6.1	6.1	0.0
Total Charge against System Operational Capital	**92.6**	**60.1**	**32.6**	**78.5**	**74.6**	**(8.8)**

Note: brackets denote deficit/overspend

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

27 October 2022

Quality and Performance Report

Agenda Item No	**ICB/10/22/09**
Report author & contact details	Andy Thomas, Associate Director of Planning
Report approved by (sponsoring Director)	Anthony Middleton, Director of Performance and Planning
Responsible Officer to take actions forward	Andy Thomas, Associate Director of Planning

Cheshire and Merseyside ICB Board Meeting

Quality and Performance Report

Executive Summary	Appendix A 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.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X		X		
Recommendation	**The Board is asked to:** • note the contents of the report and take assurance on the actions contained.				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	X		X		
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
		X			
Appendices	**Appendix A**	ICB Performance Report			

Quality and Performance Report
Board Summary

1. Urgent Care

1.1 The urgent and emergency care system continues to experience significant pressure across the whole of NHS Cheshire & Merseyside.

1.2 All acute hospitals across the system report daily against a nationally defined set of Operational Pressures Escalation Levels (OPEL). Trusts across C&M have been consistently reporting at OPEL 3 for an extended period. OPEL 3 is defined as 'the local health and social care system is experiencing major pressures compromising patient flow'. Trusts often report that they are close to OPEL 4 , the highest level of escalation and indeed there have been isolated and short term instance of OPEL 4 in recent months.

1.3 Within Acute Trusts, OPEL 3 is manifested by high bed occupancy, including significant and rising numbers of patients no longer meeting the criteria to reside in hospital. In conjunction with the continued underlying level of COVID-19, this in turn means that there are insufficient beds to admit patients from the Emergency Department or direct admissions requiring beds. This is despite attendances having reduced from the levels seen over the spring and summer of 2022.

1.4 The impact on ED of delays from decision to admit is crowding in department and in waiting areas, corridor care, ambulance handover delays and ultimately significant delays to ambulance response times, particularly Category 2 calls, which although much improved from the same period in 2021, are still much longer than the Cat 2 standard of 18 minutes.

1.5 The majority of C&M acute Trusts reporting occupancy in a range from 97%-100%, despite the opening of additional beds, i.e. escalation capacity usually reserved for winter throughout the summer due to the sustained pressure on bed capacity.

1.6 As the OPEL declaration relates to the local health and social care system as a whole, it should be noted that constant OPEL 3 or higher pressures reflect that community and mental health capacity is full, that there is pressure on GP and/or Out of Hours services, and that social services are severely constrained in their ability to facilitate care packages, discharges to care settings etc.

1.7 In terms of mitigations, the ICB is already implementing a range of actions in response to the national winter planning guidance *PR1929 Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter* issued 12 August 2022, coordinated by the Winter Planning Operational Group.

1.8 This is detailed in a separate paper on Winter Planning 2022/23, but includes Place level self-assessments and winter action plans developed in response to a national winter assurance framework, which were submitted to NHS England NW region on 26 September.

1.9 These mitigations include plans to open an additional 205 beds over the course of the winter, with the first tranche of beds (76) being opened over the course of October.

1.10 In addition the ICB has identified a Place level 'best practice checklist' for admission avoidance and discharge and has held a series of Place focused meetings to stress test plans.

1.11 The key risk to delivery remains workforce, encompassing recruitment, retention (better wages available in other sectors), skill mix/shortages, gaps in rotas, sickness etc. These issues are apparent across medical, nursing, AHPs, ambulance service, mental health and community care, and social care including domiciliary care.

1.12 *PR2090 Going further on our winter resilience plans* was issued 18 October 2022 and significantly extends the scope of the winter response, as detailed in the Winter Planning paper.

2. Elective Care & Diagnostics

2.1. The Cheshire & Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST) hosts the C&M Elective Recovery programme. The programme is focused on two key areas of performance namely recovery of elective activity to pre-pandemic levels and beyond, and the reduction of the longest waits for treatment.

2.2. Prior to the pandemic, waits of over 52 weeks for elective treatment had been eliminated in C&M. 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.

2.3. Due to the focused work on long waits across C&M, by the end of July 2022, long waits were substantially reduced, and C&M had zero patients waiting over 104 weeks except for the legitimate exemptions around patient choice.

2.4. The priority is on eliminating waits in excess of 78 weeks by the end of March 2023. As at the week ending 09 October 2022, 3,181 patients across Cheshire & Merseyside were waiting over 78 weeks. A revised trajectory has been agreed with NHS England, and the target is to reduce this to 2,726 by the end of October.

2.5. Whilst long waits for elective treatment are a recognised issue for all Trusts, the largest backlogs are at Liverpool University Hospitals (1,724), Countess of Chester (351) and St Helens & Knowsley (477) which together account for just over 80% of the 78 week challenge. The Elective Recovery Programme is leading on work across C&M to support Trusts with the management of their waiting lists, with a particular focus on supporting LUHFT and Countess of Chester.

2.6. The challenge of reducing and ultimately eliminating long waits relies not only on the actions of individual trusts, but also on collaborative efforts to increase elective activity, which includes work to improve theatre utilisation across the whole of C&M, and also the expansion of capacity through the creation of elective hubs, with the Cheshire & Merseyside Elective Centre at Clatterbridge opening this month, and the Cheshire & Merseyside Elective Centre at Broadgreen opening in January 2023.

2.7. Elective recovery is measured in terms of value-weighted elective activity for access to the Elective Recovery Fund. By this measure, the latest published data for the month ending 31 July 2022, taken from SUS puts C&M at 94.3% of 2019/20 spend value compared to 92.2% for the North West, and 94.9% for England.

2.8. A national ambition has been set for diagnostic activity across a range of common diagnostic tests to be at 120% of pre-pandemic levels. Currently C&M is performing at 118.8% for the latest reporting period.

3. Cancer

3.1. A sharp and sustained rise in urgent suspected cancer referrals (consistently 120% of pre-pandemic levels), capacity constraints experienced during each wave of COVID-19, alongside ongoing diagnostic backlogs and workforce constraints has resulted in the total cancer waiting list increasing considerably.

3.2. The over 62 day cancer backlog stands at 1,994 as at 02 October 2022. The 2022/23 ICB operational plan aims to reduce this to 713 by March 2023 which is a level judged to allow delivery of the 62 day access standard for treatment.

3.3. Levels of first treatments for cancer for latest reported month of July at 99.2% compared to 100.9% for the North West and 101.8% for England overall. C&M performance against the key operational waiting time standards is below plan: 73.97% against the 14 day urgent referral 93% standard, 66.1% against the 28 day faster diagnosis 75% standard, 94.87% against the 31 day first treatment 96% standard.

3.4. The Cheshire and Merseyside Cancer Alliance (CMCA) maintains oversight of performance across C&M including a system level Patient Tracking List (PTL), targeted support for the most challenged trusts, including LUHFT and Southport & Ormskirk who have been provided with additional resources to support rapid improvement.

3.5. Trusts are being supported with funding and project management resources to implement faster diagnosis pathways. Priority areas for 2022/23 are lower GI, prostate, lung, oesophago-gastric, gynae and head & neck.

3.6. The rollout of faecal immunochemical testing (FIT) continues at pace. A recent evaluation has shown that 67% of patients have either been downgraded from an urgent pathway, or not referred to secondary care in the first place based on their FIT result.

4. Mental Health & Learning Disabilities

4.1. The Cheshire & Merseyside Mental Health Programme is currently focused on the delivery of the mental health priorities outlined in the NHS Mental Health implementation Plan (2019/20-2023/24) which can be planned 'at scale' across C&M, with the majority of MH LTP ambitions delivered at Place.

4.2. In the same way as described above for UEC, elective care and cancer, mental health providers across C&M have experienced significant service pressures, both as a direct result of COVID-19 and as a corollary of the challenges of the wider system.

4.3. Workforce is a significant risk in terms of delivery of the LTP ambitions, across a wide range of staffing groups.

4.4. A key area of focus is winter planning, aiming to continue discharge and crisis schemes via non-recurrent funding. Prometheus contract extended to provide S136 observational support in acute hospital places of safety. Alternative conveyance solutions being explored.

4.5. For adult mental health, the 60% standard for first episode psychosis treatment with NICE recommended package of care within two weeks of referral is being met.

4.6. For Improving Access to Psychological Therapies (IAPT) which provides access to talking therapies for adults with anxiety and depression, the position is positive, both in term of access and in terms of the wait from first appointment to second i.e. from first assessment to treatment.

4.7. For perinatal mental health services a system recovery plan is in place to increase investment in line with NHS Long term Plan ambitions.

4.8. For physical health checks for people with severe mental illness, the improving trajectory reflects that QOF has been reinstated in primary care. CORE20PLUS5 initiatives are also expected to contribute to this.

4.9. For Out of Area Placements, please note that due to a data quality issue the numbers were overstated in previous returns. The June figure now accurately reflects the actual position. The ICB aims to have no patients placed out of area by March 2023.

5. Summary/Recommendations

5.1. The Board is asked to:

- **note** the contents of the report and take assurance on the actions contained.

NHS
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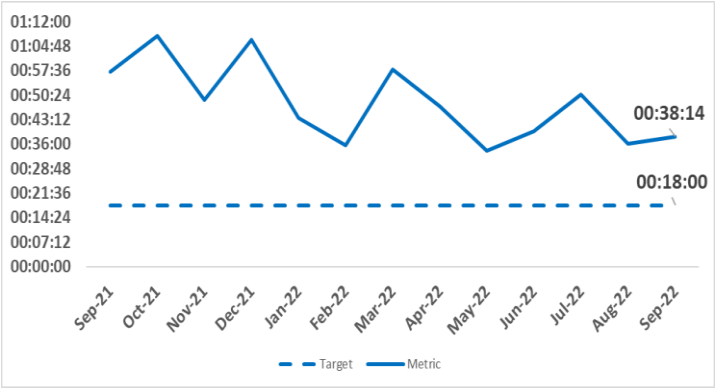
Performance Report

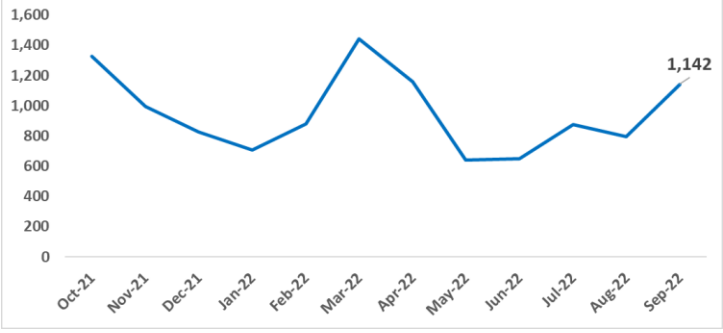
Section II: Urgent Care

Ambulance Response times – Cat 2



Organisation	Jul-22	Aug-22	Sep-22
Cheshire & Merseyside	00:50:28	00:36:06	00:38:14
North West	00:39:07	00:41:12	00:44:35
England	00:54:08	00:36:06	00:40:57

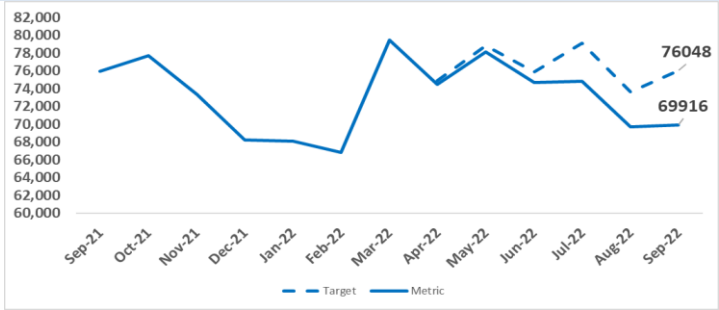
Ambulance Arrival to handover >60 mins

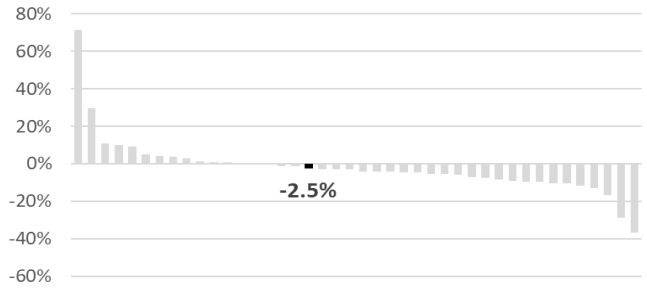


Organisation	Jul-22	Aug-22	Sep-22	Oct-22*
Cheshire & Merseysic	876	796	1142	474
North West	3517	3407	3990	1419
England				

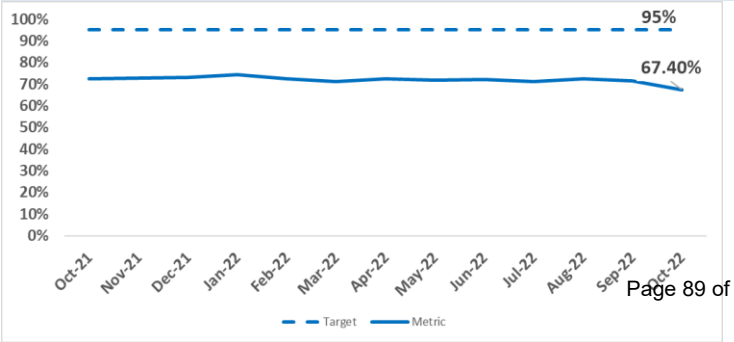
* - To 9th October

A&E Attendances (Type 1)





A&E 4 Hour Standard



Organisation	Jul-22	Aug-22	Sep-22	*Oct-22
Cheshire & Merseyside	71.10%	72.50%	71.60%	67.40%
North West**		68.90%	66.30%	65.10%
England**		71.30%	67.90%	67.40%

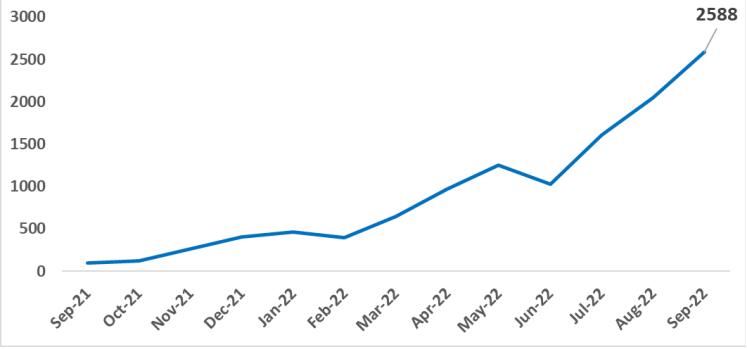
* - To 3rd October

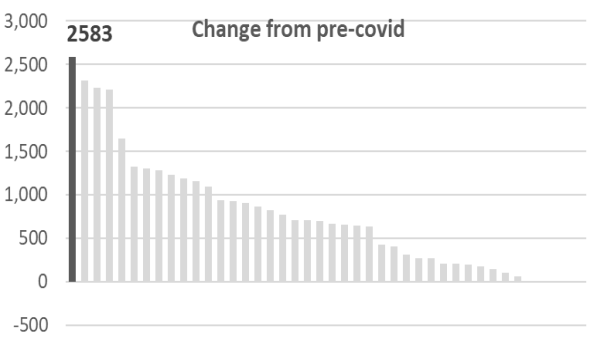
** - Performance as measured in final week

NHS
Cheshire and Merseyside

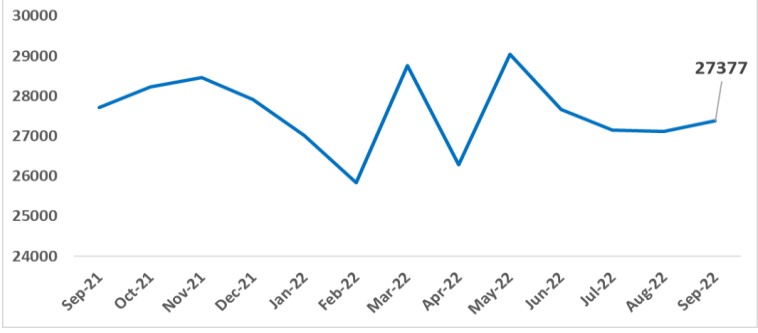
Section II: Urgent Care

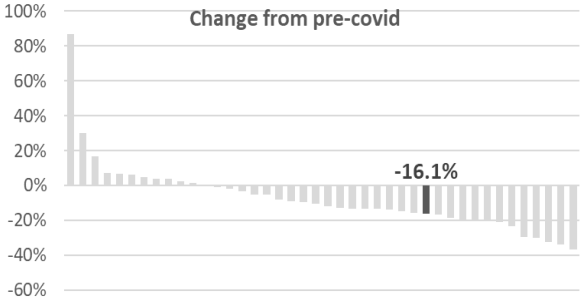
A&E 12 hour delays from decision to admit



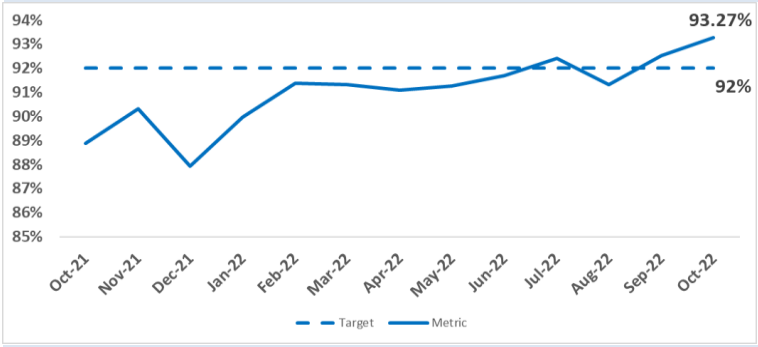


Total Emergency admissions





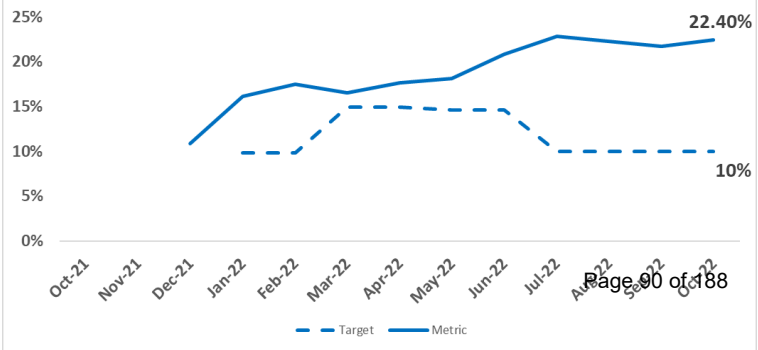
Bed Occupancy General & Acute



Organisation	Jul-22	Aug-22	Sep-22	Oct-22*
Cheshire & Merseyside	92.4%	91.3%	92.5%	93.3%
North West	92.3%	92.1%	92.9%	
England	92.9%	92.6%	93.4%	

* - Daily average to 18th October

No longer meeting criteria to reside (Percentage of G&A bed stock)



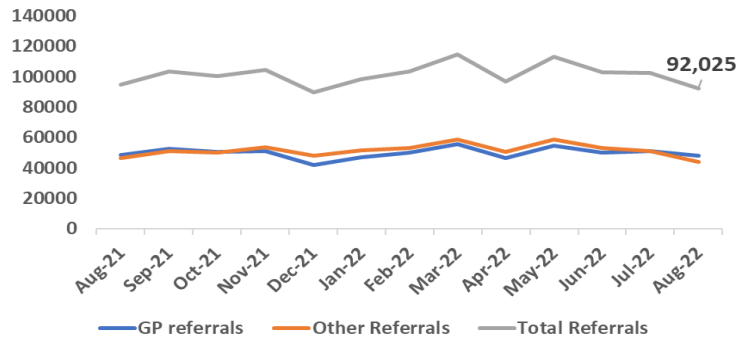
Organisation	Jul-22	Aug-22	*Sep-22	*Oct-22
Cheshire & Merseyside	22.80%	22.30%	21.70%	22.40%
North West	20%	19.50%	16.80%	19.20%
England				

* On 30th September
* On 16th October

NHS
Cheshire and Merseyside

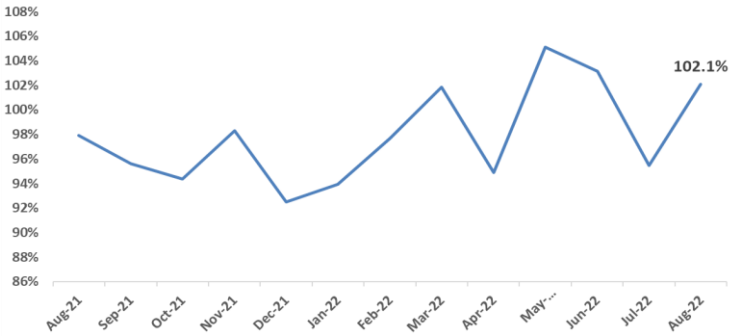
Section II: Planned Care

Referrals - August 22



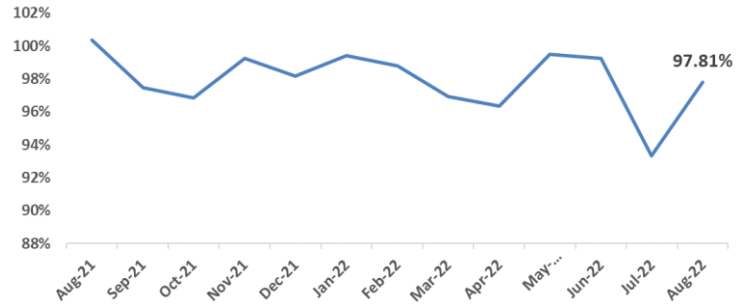
Organisation	Jun-22	Jul-22	Aug-22
Cheshire & Merseyside	102,951	102,259	92,025
North West	231,542	230,357	232,540
England	1,775,937	1,798,905	1,835,606

Outpatient First % of pre-COVID activity (comparison with 2019/20)



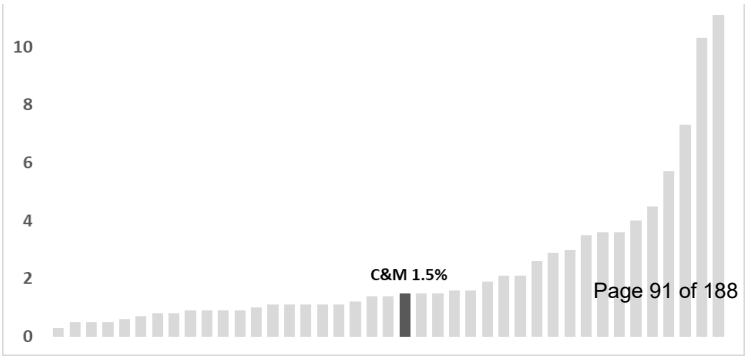
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	103.2%	95.5%	102.1%
North West	N/A	N/A	N/A
England	99.0%	95.1%	96.7%

Outpatient Follow-up % of pre-COVID activity - August 22



Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	99.25%	93.31%	97.81%
North West	N/A	N/A	N/A
England	102.10%	97.46%	99.83%

Patient Initiated Follow-up (PIFU) ICS Benchmark - August 22

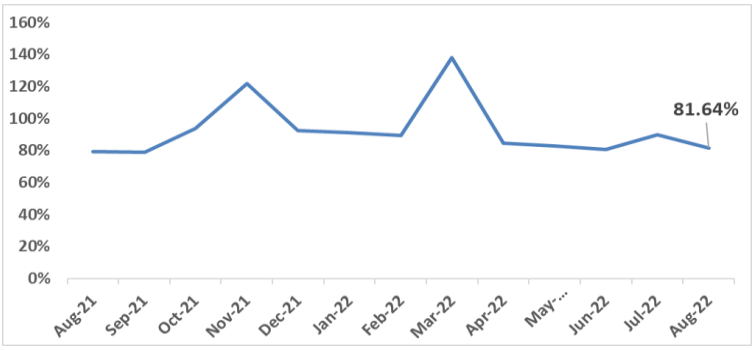


Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	2.2%	1.0%	1.5%
North West	1.4%	1.0%	1.5%
England	1.6%	1.6%	1.5%

NHS
Cheshire and Merseyside

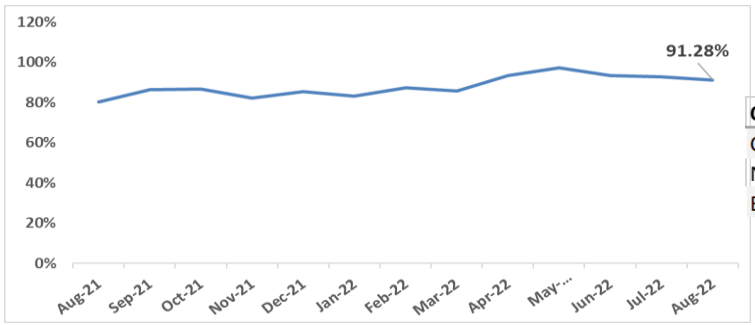
Section II: Planned Care

Elective inpatient admissions % of pre-COVID activity - August 22



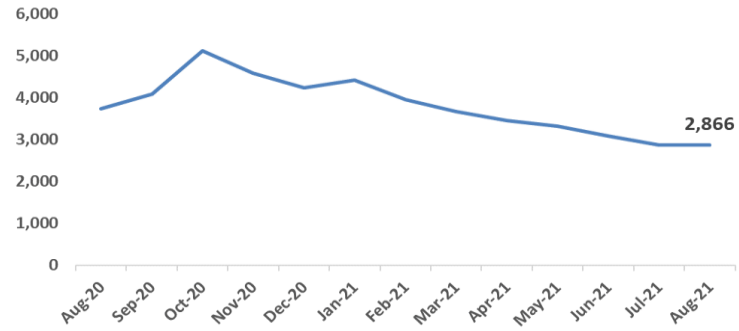
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	80.78%	89.95%	81.64%
North West	N/A	N/A	N/A
England	84.22%	87.23%	81.24%

Day cases % of pre-COVID activity - August 22



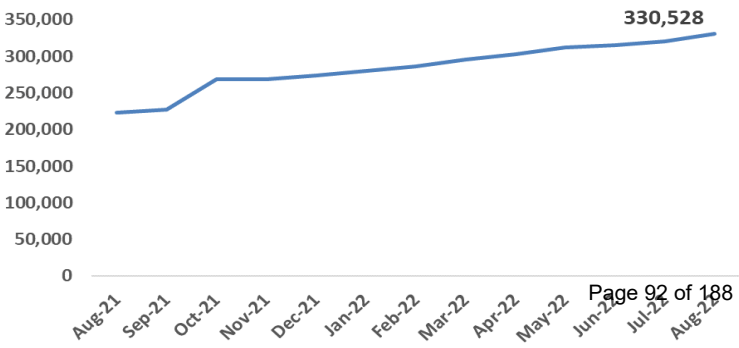
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	93.39%	92.80%	91.28%
North West	N/A	N/A	N/A
England	94.69%	95.54%	95.05%

The number of people waiting 78 Weeks or more - August 22



Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	3094	2866	2866
North West	8416	8793	9345
England	53911	51838	50888

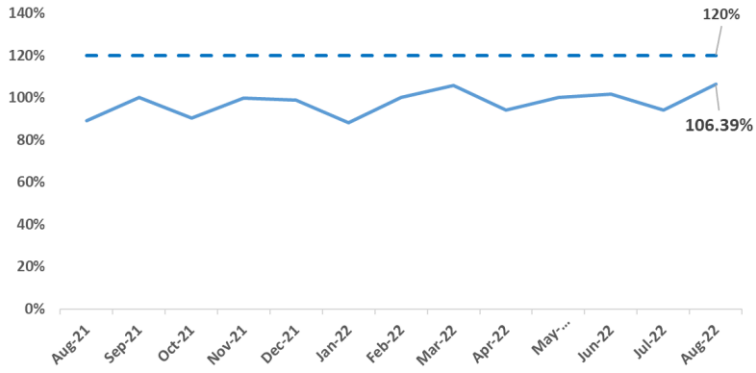
Waiting list (RTT total incompletes) - August 22



Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	315,138	320,215	330,528
North West	907,213	928,072	951,384
England	6,248,645	6,351,957	6,507,743

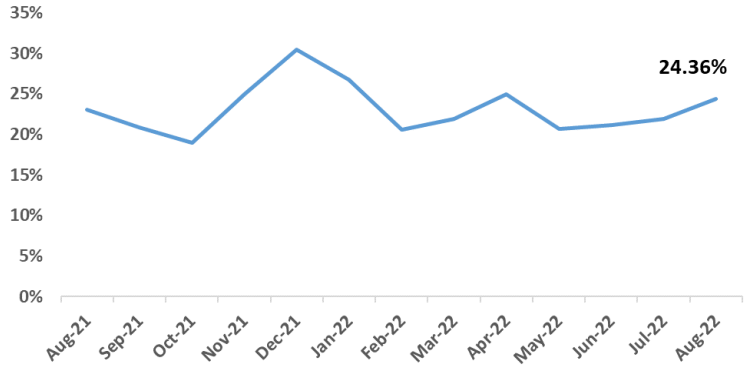
Section II: Planned Care

Diagnostic Activity: % of pre-COVID activity (March 2019 to February 2020) - August 22



Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	101.84%	94.18%	106.39%
North West	100.65%	93.84%	102.91%
England	101.20%	93.98%	105.15%

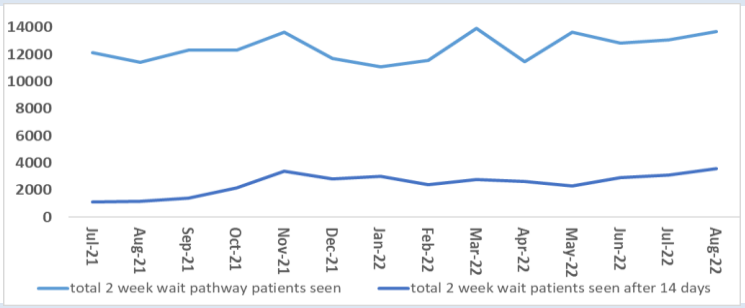
Diagnostic 6 week wait – objective no more than 1%



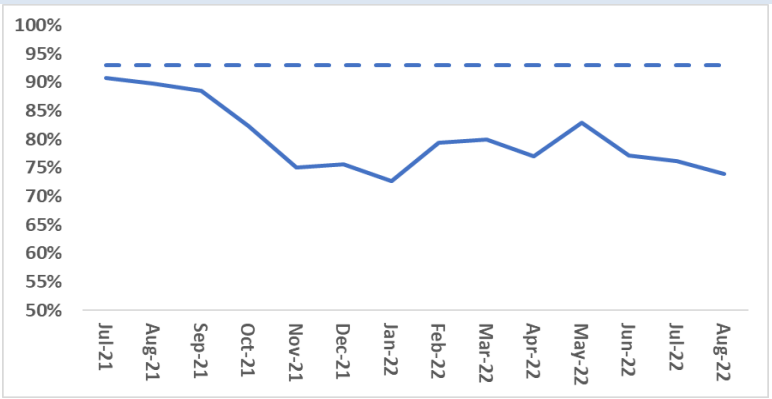
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	21.16%	21.92%	24.36%
North West	26.90%	26.30%	30.63%
England	70.73%	70.73%	73.17%

Section IV: Cancer Care

The number of 2 week wait pathway patients seen * *proxy for referrals*

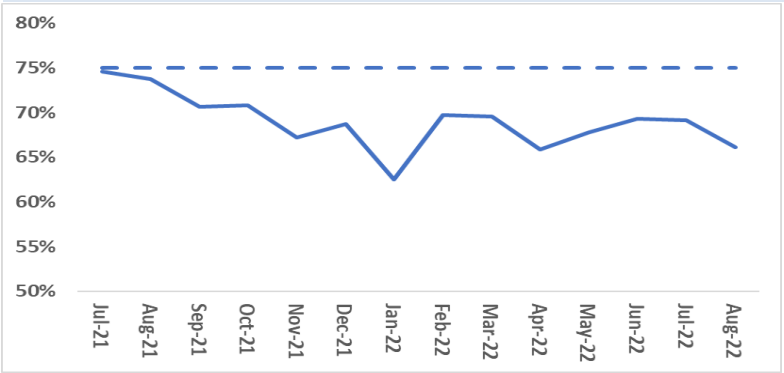


% of patients who waited for less than 14 days to be seen after referral



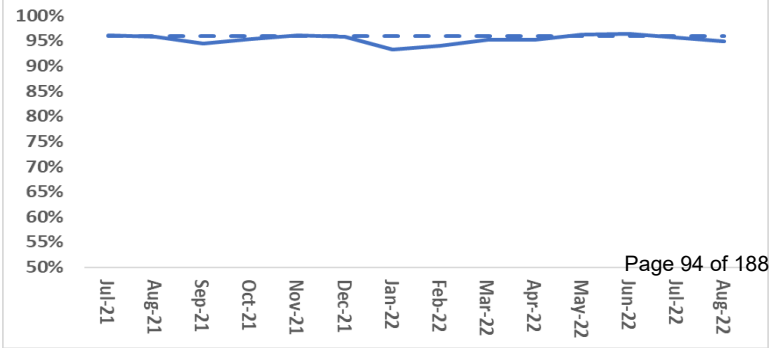
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	77.16%	76.15%	73.97%
North West	75.20%	75.80%	71.07%
England	77.70%	77.80%	75.60%

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



Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	69.30%	68.90%	66.10%
North West	67.60%	66.30%	65.30%
England	70.30%	71.09%	69.45%

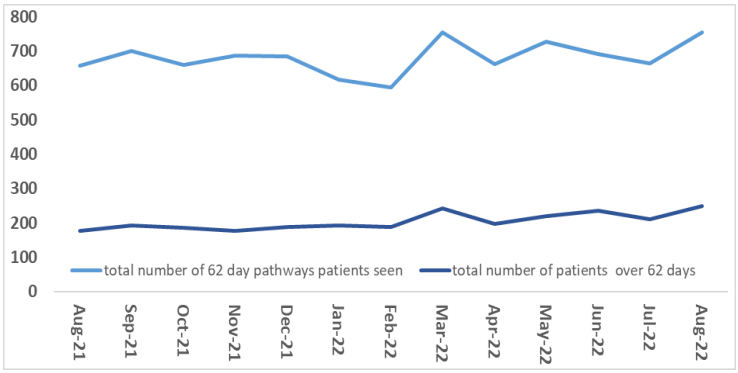
% of patients diagnosed with cancer receiving treatment within 31 days of diagnosis



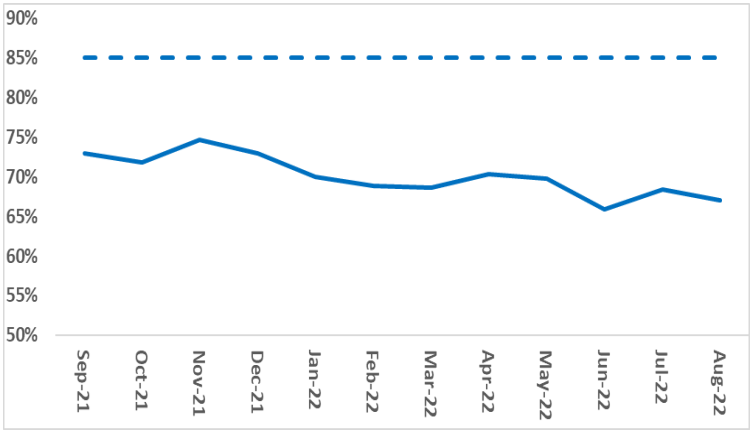
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	96.10%	96.30%	94.87%
North West	93.00%	94.40%	93.10%
England	91.80%	92.90%	92.09%

Section IV: Cancer Care

Number of patients receiving treatment for cancer treatment by their GP waiting on 62 day pathway

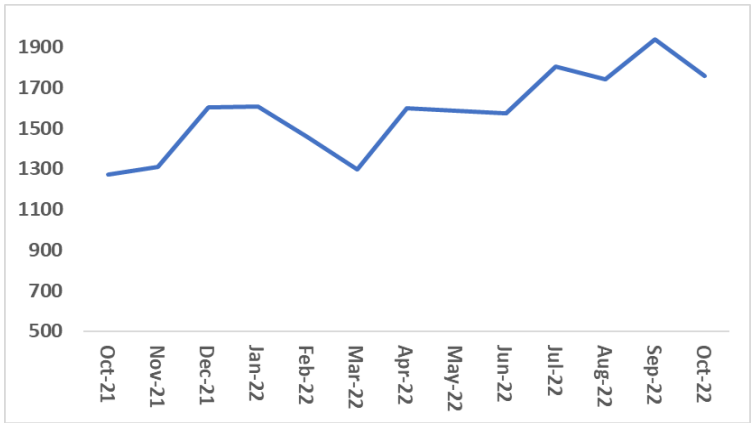


% Patients referred for cancer treatment by their GP waiting less than 62 days for treatment to start



Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	65.10%	68.37%	67.57%
North West	59.00%	61.30%	60.70%
England	59.90%	61.60%	61.90%

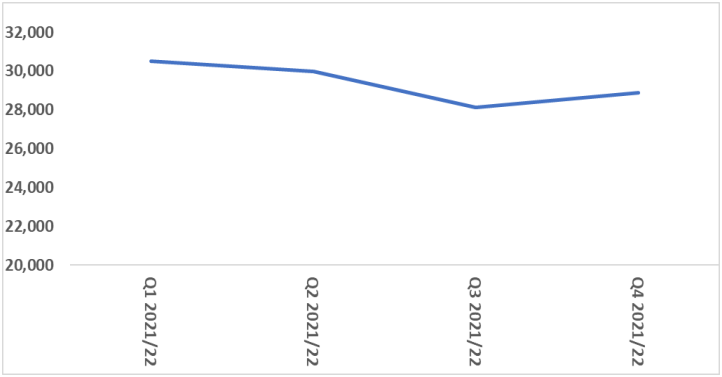
Over 62 day cancer backlog *as at 2nd Oct 22



Organisation	Jul-22	Aug-22	Sep-22	Oct-22
Cheshire and Merseyside	1805	1741	1938	1760
North West	4675	4489	5422	5502
England	30414	31036	33814	33510

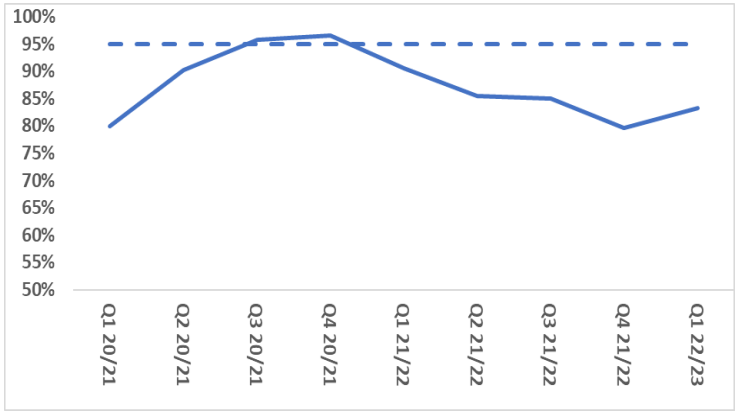
Section V: Mental Health

Children and young people (ages 0-17) mental health services access (number with 1+ contact)



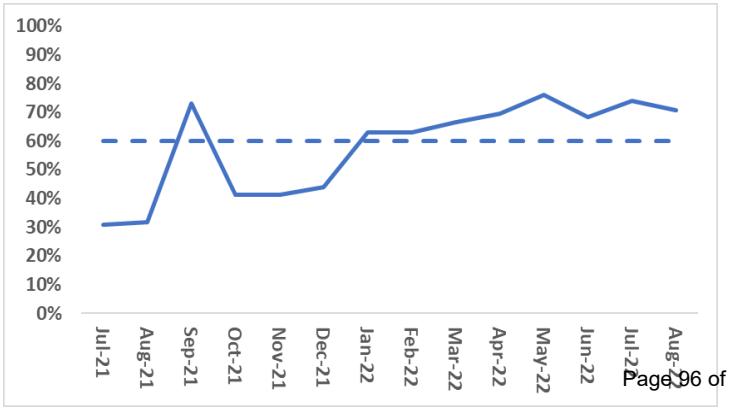
Organisation	Q2 21/22	Q3 21/22	Q4 21/22
Cheshire and Merseyside	29,985	28,115	28,890
North West	90,390	87,630	92,870
England	628,454	640,476	674,485

% of children and young people with eating disorders seen within 1 week (Urgent): *rolling 12 months



Organisation	Q3 21/22	Q4 21/22	Q1 22/23
Cheshire and Merseyside	85%	79.6%	83.3%
North West	85%	90.9%	71.0%
England	59%	61.9%	68.1%
* 12 months to end of quarter			

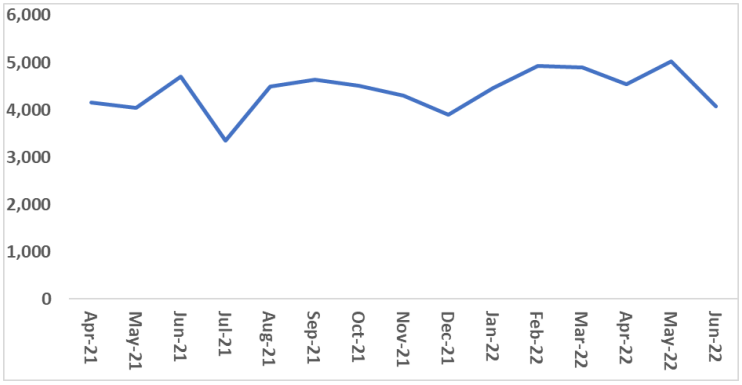
% of open referrals on EIP pathway that waited for treatment within two weeks *rolling 3 months



Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	68.18%	74.07%	70.83%
North West	-	-	-
England	67.80%	68.80%	69.50%

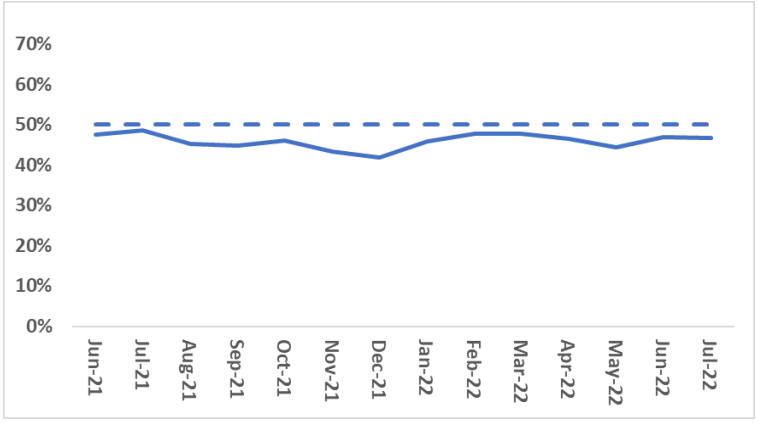
Section V: Mental Health

IAPT access: No of people entering NHS funded treatment



Organisation	Apr-21	May-21	Jun-21
Cheshire and Merseyside	4535	5020	4080
North West	13538	14682	12789
England	96515	110327	98827
source: NHS futures core data pack			

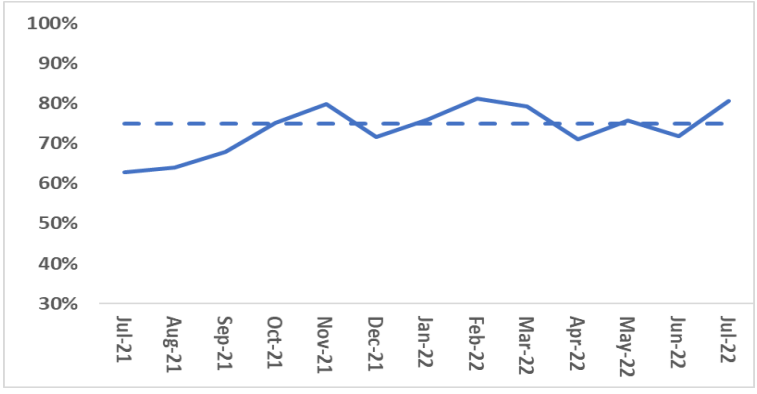
IAPT recovery: % of people that attended at least 2 treatment contacts and are moving to recovery



Organisation	Apr-22	May-22	Jun-22
Cheshire and Merseysi	46.00%	44.38%	47.03%
North West	49.00%	49.00%	47.00%
England	50.50%	50.10%	49.60%

*Benchmarking is a month in arrears

The percentage of IAPT Waiting under 6 weeks



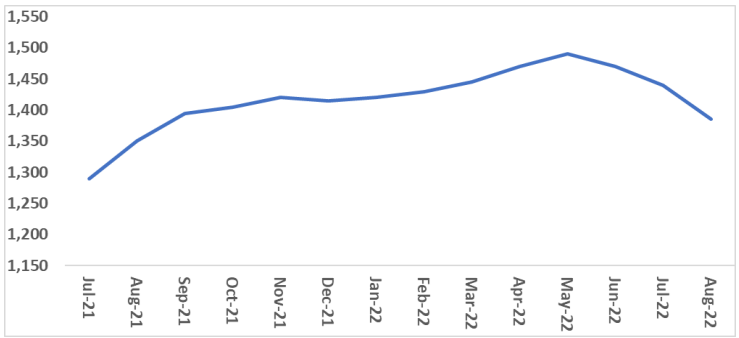
Organisation	Apr-22	May-22	Jun-22
Cheshire and Merseysi	71.00%	75.65%	71.91%
North West	69.00%	71.00%	68.00%
England	74.20%	76.10%	73.20%

*Benchmarking is a month in arrears

NHS
Cheshire and Merseyside

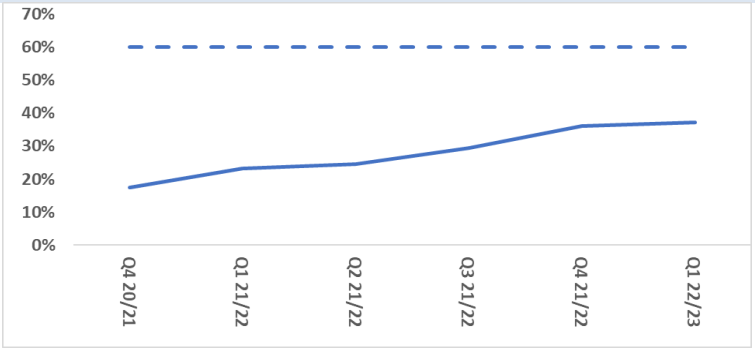
Section V: Mental Health

No of women accessing specialist community perinatal mental health services *rolling 12 months



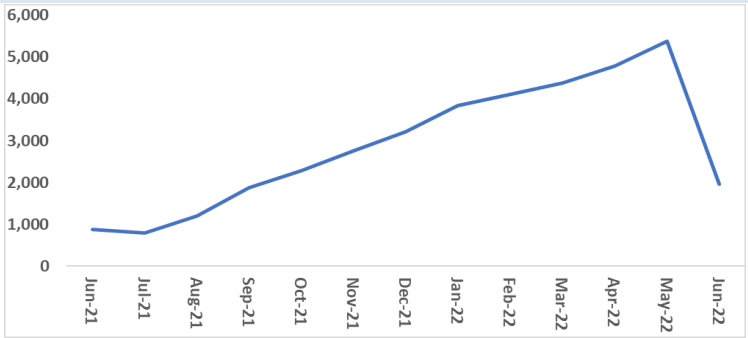
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	1,500	1,440	1,385
North West	5,540	5,545	5,525
England	45,410	44,865	44,790

Physical health checks for people with severe mental illness



Organisation	Q3 21/22	Q4 21/22	Q1 22/23
Cheshire and Merseyside	29.4%	36.2%	37.2%
North West	32.1%	41.7%	42.0%
England	34.9%	42.8%	43.5%
source: NHS Statistics SMI published data			

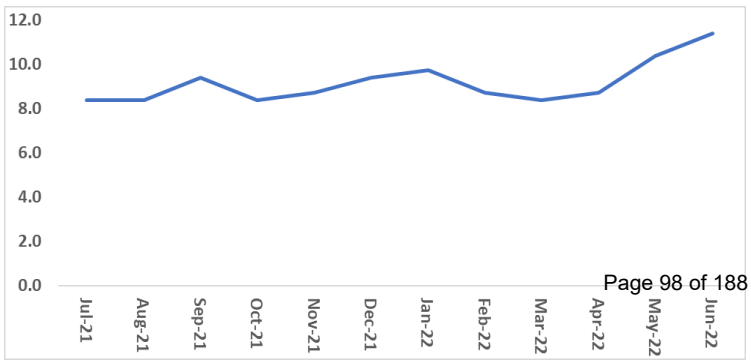
Total number of inappropriate adult acute mental health out of area placements bed days : *rolling 3 month periods*



Organisation	Apr-21	May-21	Jun-21
Cheshire and Merseyside	4,765	5,380	1,960
North West	9,730	9,110	5,555
England	53,575	54,090	51,390
source: NHS futures OAP report			

* Data quality issues addressed from June (over-reported in previous periods)

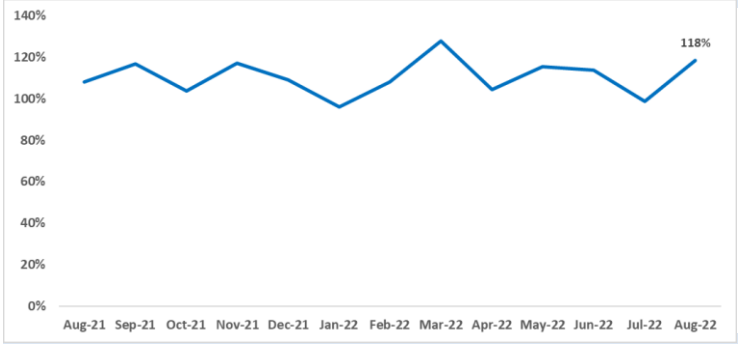
Rate of people discharged per 100,000 from adult acute beds aged 18 to 64 with a length of stay of 60+ days



Organisation	Apr-21	May-21	Jun-21
Cheshire and Merseyside	8.72	10.39	11.40
North West	9.05	10.47	11.40
England	7.28	7.73	7.01

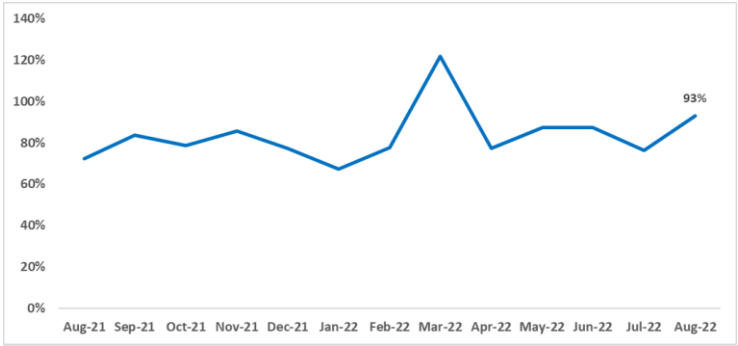
Section VI: Primary Care

Total appointments delivered against pre-covid baseline



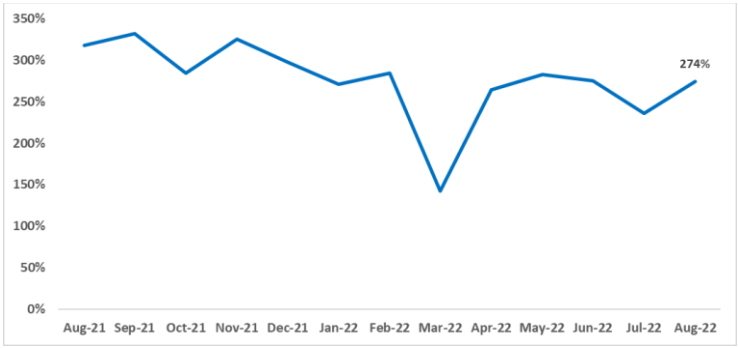
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	113.8%	100.1%	118.5%
North West	113.3%	99.7%	122.4%
England	111.3%	98.5%	117.7%

Face to Face appointments delivered against pre covid baseline



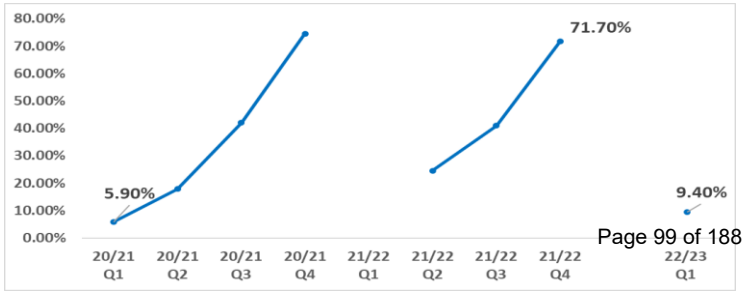
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	92.7%	75.5%	89.1%
North West	91.4%	81.2%	94.0%
England	90.8%	81.0%	93.5%

Telephone appointments delivered against pre-covid baseline



Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	275.2%	236.2%	274.5%
North West	323.9%	278.8%	322.6%
England	260.1%	225.1%	256.6%

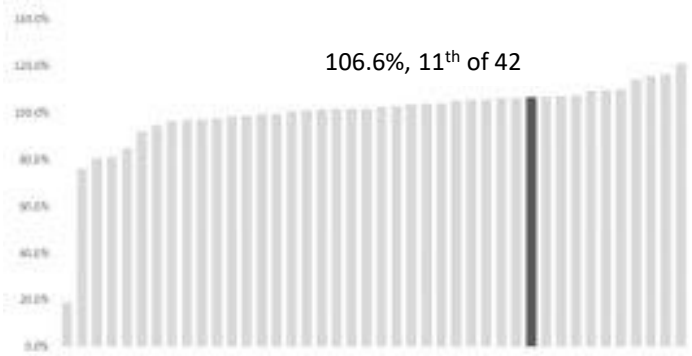
Number of people aged 14+with a learning disability on the GP register receiving an annual health check



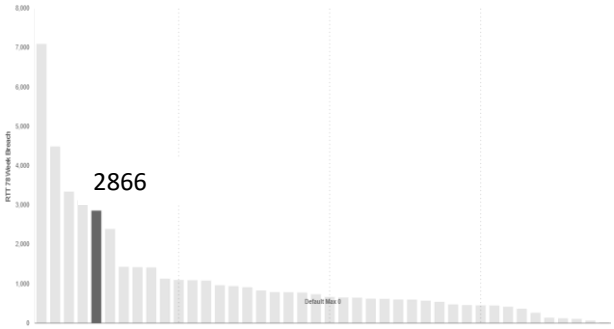
Organisation	Jun-22	Jul-22	Aug-22
Cheshire & Merseyside	9.4%	14.1%	18.7%
North West	9.3%	13.8%	18.7%
England	10.4%	15.0%	20.2%

ICB – National Performance Ambition Metrics

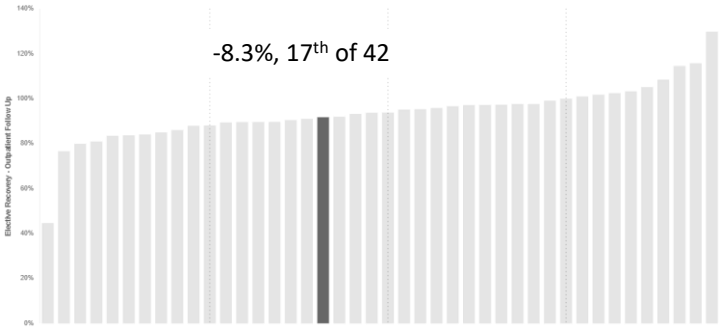
Increase diagnostic activity to 120% pre-pandemic levels



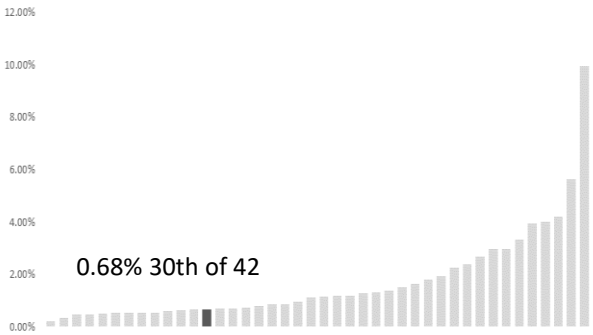
Eliminate 78 week waiters by the end of March 2023



25% reduction in outpatient follow up attendances

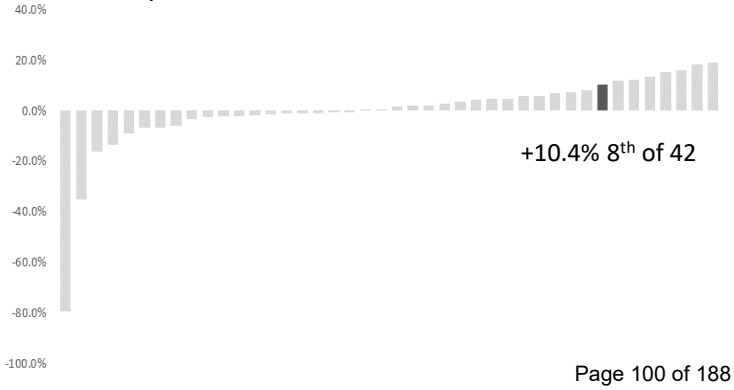


5% of outpatient attendances to convert to PIFU pathways

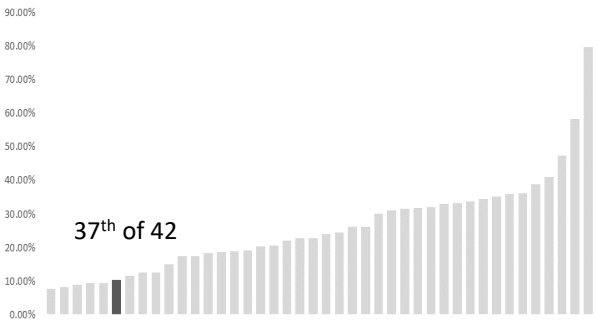


10% more patients to complete treatment through a combination of completed pathways (4% via clock stops and 6% via Advice & Guidance deflections)

Clock stops



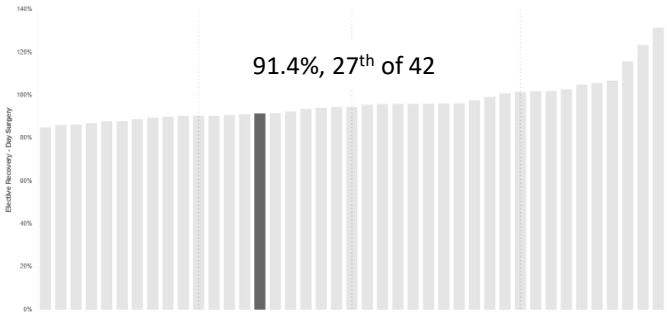
Advice & Guidance



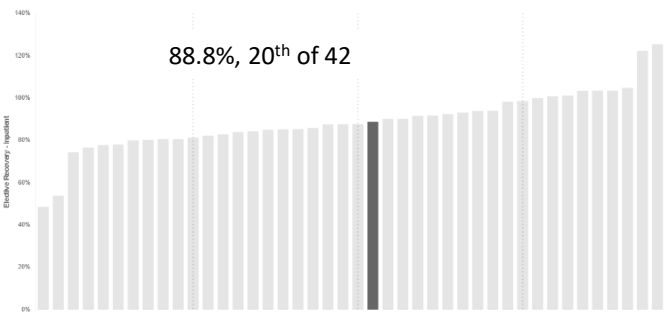
ICB – National Performance Ambition Metrics

Increase day cases, ordinary admissions, OPFA and OP with procedures (excluding OPFU) by 10% on 2019/20 levels

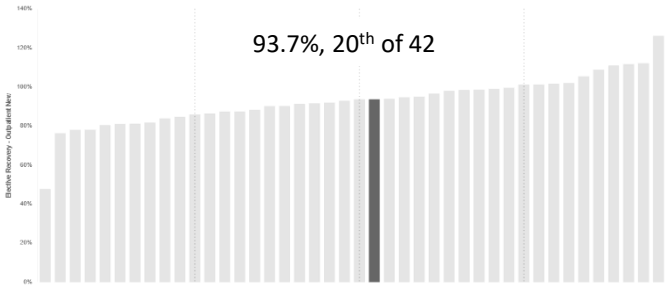
Day case



Ordinary admissions



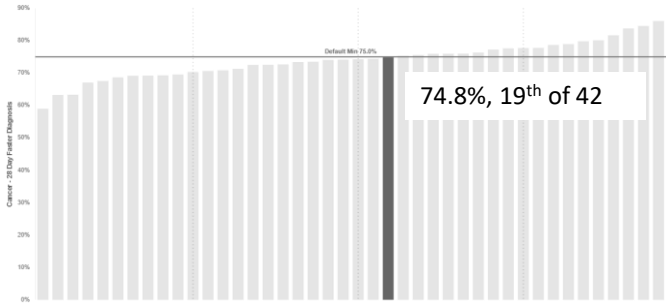
Outpatient new



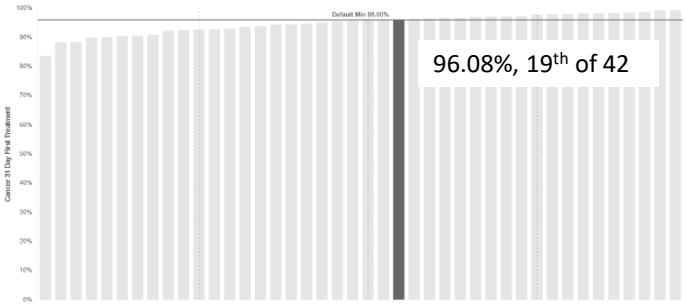
ICB – National Performance Ambition Metrics

Improvements to cancer treatments against cancer standards (62 days urgent ref to 1st treatment, 28 faster diagnosis & 31 day decision to treat to 1st treatment)

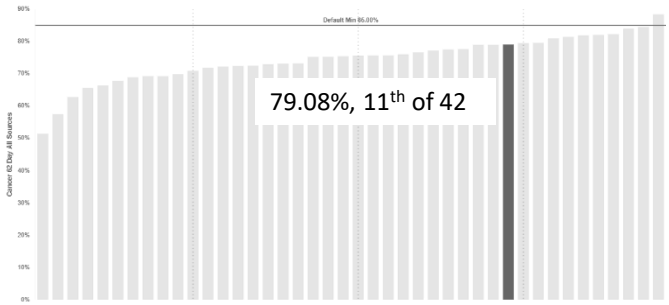
28 day faster diagnosis (75% standard)



31 day decision to treat (96% standard)



62 day referral to treat (85% standard)



NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

27 October 2022

Executive Director of Nursing & Care Report

Agenda Item No	**ICB/10/22/10**
Report author & contact details	Michelle Creed, Interim Associate director of Nursing & Care Kerry Lloyd, Deputy Director of Nursing & Care
Report approved by (sponsoring Director)	Report approved by Chris Douglas Executive Director of Nursing & Care
Responsible Officer to take actions forward	Chris Douglas, Executive Director of Nursing & Care

Cheshire and Merseyside ICB Board Meeting

NHS Cheshire and Merseyside

Executive Director of Nursing & Care Report

Executive Summary	The Purpose of this report is to provide assurance from the Executive Director of Nursing & Care to the Cheshire and Merseyside (C&M) Integrated Care Board (ICB) regarding the quality, safety and patient experience of services commissioned and provided across the geographical area of Cheshire & Merseyside. The report outlines the progress that the ICB has made regarding quality, safety and patient experience of services commissioned and provided across the geographical area of C&M. It demonstrates the progress made of the arrangements in place for ensuring the fundamental standards of quality are adopted and delivered.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X		X		X
Recommendation	**The Board is asked to:** • to note the content of the report				
Key issues	Headline findings of the One to One Midwifery Provider NHS England commissioned review by Niche Health and Social Care Consulting.				
Key risks	Outlined within the report				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
			X		
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
		X	X	X	
Route to this meeting	The quality, surveillance, oversight and assurance has been discussed and approved by the Quality & Performance Committee August 2022, September 2022.				
Management of Conflicts of Interest	N/A				
Patient and Public Engagement	N/A				
Next Steps	N/A				

Executive Director of Nursing & Care Report

1. Summary

1.1 The Purpose of this report is to provide assurance from the Executive Director of Nursing & Care to the C&M ICB Board regarding the quality, safety and patient experience of services commissioned and provided across the geographical area of Cheshire & Merseyside.

1.2 At the time of writing this report, it has not been possible to incorporate the main findings of the Kirkup enquiry into maternity services into East Kent maternity Services. I will update the Board verbally at its October meeting of what this means for ICBs and what actions we will intend to take locally to reflect upon and learn from Kickup recommendations.

2. NHS and Independent Provider Trusts

2.1 **Liverpool University Hospitals NHS Foundation Trust (LUHFT**). LUHFT remains in System Oversight Framework Level 4 with a System Improvement Board in place led by NHSE. The Trust remains challenged in delivery against a number of quality metrics. The transfer to the new hospital site is underway and there have been no reported patient safety incidents at the time of reporting.

2.2 Liverpool 'place' continues to meet with the Trust on a monthly basis to obtain assurance around its operational delivery of safe services and have reported the need for increased traction in relation to the improvement some key quality and performance metrics. This work dovetails into the regulatory requirements that the Trust must deliver.

2.3 At the September 2022 Quality & Performance Committee, Liverpool place presented a CQC Urgent and Emergency Care review, this was discussed in depth, with a further request to bring the associated and emerging improvement plan to the November 2022 Committee for further assurance.

2.4 The Executive Director of Nursing and Care for the ICB is meeting with the Chief Nursing officer for LUHFT to explore how the ICB can support in the quality improvement of commissioned services and in ensuring the quality oversight and assurance framework in place is effective.

2.5 **Countess of Chester Hospitals NHS Foundation Trust.** The provider is in NHS England System Oversight Framework level 3. Enhanced Quality Surveillance has been in place across 2021/22 in response to long standing concerns relating to quality and safety of services. There is a System Improvement Board in place, chaired by the North-West regional Chief Nurse, with an Improvement Director now appointed.

2.6 Cheshire West Place is reporting 'Partial' assurance on progress to date. Oversight continues in relation to regulatory notices and input continues from the Maternity Safety Support Programme.

2.7 The C&M ICB has commissioned Midlands and Lancashire Commissioning Support Unit to assist the Trust to progress delivery of key areas in their improvement plan, for a period of 3 months from 01/09/2022. The Executive Director for Nursing and Care for C&M ICB met with the Executive Director for Nursing and the lead for the external governance support to review progress against the commissioned areas requiring additional support on the 14th October 2022 and areas requiring additional action/traction were agreed.

2.8 **East Cheshire Trust.** The resilience of services within East Cheshire Trust continues to be a focus for assurance, impacting upon waiting times and responsiveness. There are particular challenges in relation to endocrinology and cardiology provision, with assurance received in relation to remedial actions being taken through partnership working and collaboration.

2.9 The Trust has an extensive clinical strategy programme with Stockport Trust for an agreed number of services and this plan has been shared publicly. Workforce resilience is a key focus as the Trust, along with Cheshire East place, work together to source mutual aid to support short to medium term solutions whilst long term strategy progresses.

2.10 A detailed report on the Trust was received at the October 2022 C&M Quality & Performance Committee. Cheshire East's Associate Director of Quality presented that the Trust has an open and transparent culture of reporting and collaboration and that commissioners were assured by the sub-contractual governance arrangements in place with other partner organisations that support service stability and resilience.

3. Patient Safety

3.1 **Reports to Prevent Future Deaths (PFD) and Regulation 28 notifications.** Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths.

3.2 All reports and responses must be sent to the Chief Coroner. In most cases the Chief Coroner will publish them on this website. The Chief Coroner's policy on the publication and redaction of reports and responses is available here: PFD publication policy 9 11 21 Regulations 28 and 29, Coroners (Investigations) Regulations 2013 (external link, opens in a new tab) set out the procedures that apply to reports and responses. The Chief Coroner has also issued guidance on the process which you can access here: REPORTS – ACTION TO PREVENT FUTURE DEATHS.

3.3 Oversight of PFD's has to date been undertaken by NHS England Regional Office, this will now pass to C&M Integrated Care Board and a transitional arrangement has commenced:

- NHS England regional team will be responsible for checking all North-West Coroners websites and flagging those related to C&M ICB
- Deputy Director of Nursing & Care will act as C&M lead
- C&M ICB next steps are to determine where the central repository and tracker will sit that captures all coronial activity
- Development of a standard operating procedure is also in development
- NHS England will share tools that support in ensuring learning is elicited from cases.

4. Quality, Surveillance, Oversight and

4.1 **One to One Midwifery Independent Investigation Report.** Niche Health and Social Care Consulting were asked by NHS England to review the circumstances which led to the cessation of community maternity services provided by One to One Midwives. The work included consideration of the commissioning and contracting processes, governance and oversight, and financial viability as well as the chronology of events which led to the cessation of the service. The report was embargoed at the time of writing this briefing, however, there are recommendations for:

- National and System learning
- Commissioners
- NHS Providers
- Independent Sector Providers.

4.2 The published report summary was reviewed at C&M Quality & Performance Committee in October 2022 and committee members discussed the findings.

4.3 NHS England are holding a stakeholder Action Planning meeting on 28 October 2022 which will be followed by an assurance framework. C&M ICB will be represented at the meeting and further updates on progress taken to committee by way of assurance.

4.4 **Children and Young People.** The North-West Children and Young Persons (CYP) Transformation Board took place on the 18 October 2022, with the C&M ICB/ICS represented by a range of system partners. The ICB presented its emerging structure and governance arrangements, which was well received, as well as the work undertaken in relation to clinical priority areas. A facilitated workshop is to be convened to with North-West representation to explore the specific workforce challenges being experienced across the health and social care sector.

5. Workforce

5.1 The NHS's greatest strength is its people, and as demand for healthcare continues to grow, it is essential that NHS staff get the support they need to do their jobs effectively.

5.2 Through better recruitment and retention, the NHS Long Term Plan will ensure there are enough people working in the NHS to support patients, and that they get the support they need to continue delivering the best possible care.

5.3 It will also strengthen the quality of NHS leadership, while improving the working environment for frontline staff, from support to manage their own health and wellbeing, to investing in the digital technology that can help them do their jobs more easily.

5.4 Cheshire & Merseyside Nursing, Midwifery & AHPs Workforce Development Programme via 11 workstreams (listed below) have undertaken a significant amount of work during 2021/22. This work spans nursing, midwifery and allied health professional workforce across health and social care:

- Continued Professional Development Framework
- Rotational Scheme
- Workforce Programme – Share the Learning Platform and Communication Strategy
- Workforce Charter
- Preceptorship Programme
- Clinical and Professional Leadership and Quality Improvement Development Programme
- Primary Care Engagement and participation
- Social Care engagement and participation
- Allied Healthcare Professionals (AHP) engagement and participation
- Accessible workforce data
- System Wide Initiatives.

5.5 It is proposed to present a thematic workforce focus celebrating progress to date and next steps at the ICB Board in November 2022.

6. Conclusion

6.1 The Integrated Care Board should be assured that the system surveillance process is in place to identify best practice and sport early warning signs of system failure. However, this system and process will need to be reviewed considering changing organisational forms, the financial recovery climate and engagement and involvement public requirements.

6.2 The Executive Director of Nursing & Care will submit a monthly report to the Integrated Care Board for consideration and challenge.

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

27 October 2022

Continuous glucose monitoring (CGM) and flash glucose monitoring

Agenda Item No	**ICB/10/22/11**
Report author & contact details	Mrs Susanne Lynch MBE, Chief Pharmacist and Dr Fiona Lemmens, Deputy Medical Director and MLCSU
Report approved by (sponsoring Director)	Professor Rowan Pritchard-Jones, Medical Director
Responsible Officer to take actions forward	Professor Rowan Pritchard-Jones

Continuous glucose monitoring (CGM) and flash glucose monitoring

Executive Summary	NICE has issued updated guidance on criteria for use of Continuous Glucose Monitoring and flash glucose monitoring and now recommends patients with Type 1 diabetes and some patients with Type 2 diabetes are offered this option. NICE have made these recommendations after economic analysis has shown them to be cost effective. There are significant outcome benefits for patients and longer-term cost saving benefits for the system through improved diabetes control as a result of these new devices.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
		X			
Recommendation	**The Board is asked to:** • **approve** the retirement of the current Cheshire & Merseyside Continuous Glucose Monitoring (CGM) policy, and • **approve** the recommendations for CGM and flash glucose monitoring within NICE NG17, NG18 and NG28.				
Key issues	The impact of the implementation of the guidance in terms of the cost of devices is significant and there are expected to be additional workforce impacts as more patients require specialist input to ensure they are provided the best option for their particular circumstances.				
Key risks	• impact of additional cost • impact of needing additional workforce.				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	X		X		
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
		X			
Route to this meeting	The Cheshire and Merseyside Strategic Clinical network, local diabetes clinicians and the medicines optimisation teams across Cheshire and Merseyside have been working closely together to assess the impact of the new NICE guidance for our population. The recommendations in this paper are based on their collective clinical advice to the ICB medical directorate				
Management of Conflicts of Interest	None are anticipated. Members of the ICB Board will need to identify any if the approval of the recommendations within the report in any way benefits them.				
Patient and Public Engagement	Engagement was undertaken through the development of the NIVE guidance, and through the results of clinical trials.				
Next Steps	If approved the Cheshire and Mersey Prescribing Formularies will be updated and the guidance rolled out across primary and secondary care providers.				

Continuous glucose monitoring (CGM) and flash glucose monitoring

1. Executive Summary

1.1 NICE has issued updated guidance (NG18 Type 1 Children,[1] NG 17 Type 1 adults[2] and NG 28 Type 2 adults[3]) on criteria for use of Continuous Glucose Monitoring (CGM) and flash glucose monitoring and now recommends patients with Type 1 diabetes and some patients with Type 2 diabetes are offered this option. NICE have made these recommendations after economic analysis has shown them to be cost effective.

1.2 The impact of the implementation of the guidance in terms of the cost of devices is significant and there are expected to be additional workforce impacts as more patients require specialist input to ensure they are provided the best option for their particular circumstances.

1.3 There are significant outcome benefits for patients and longer-term cost saving benefits for the system through improved diabetes control as a result of these new devices.

1.4 The board is asked to approve the retirement of the current Cheshire & Merseyside CGM policy and approve the recommendations for CGM and flash glucose monitoring within NICE NG17, NG18 and NG28 to become the new Cheshire and Merseyside policy.

2. Background

2.1 The current Cheshire and Merseyside CGM policy was developed in 2017 with the criteria for use based on the original NICE recommendations in NICE NG17 and NG18. Individual CCGs ratified the CGM policy for their area, but prior to the establishment of the ICS, not all CCGs had ratified the most recent update to the policy, meaning that access to CGM across Cheshire and Merseyside is currently not equitable in all areas.

2.2 On 31 March 2022, NICE published updates to NG18 for children with Type 1 diabetes, NG17 for adults with Type 1 diabetes and NG28 for adults with Type 2 diabetes. The new guidance increases the availability of CGM to a larger cohort of patients than the Cheshire and Merseyside policy currently does.

2.3 The Cheshire and Merseyside Strategic Clinical network, local diabetes clinicians and the medicines optimisation teams across Cheshire and Merseyside have been working closely together to assess the impact of the new NICE guidance for our population. The recommendations in this paper are based on their collective clinical advice to the ICB medical directorate.

[1] https://www.nice.org.uk/guidance/ng18
[2] https://www.nice.org.uk/guidance/ng17
[3] https://www.nice.org.uk/guidance/ng28

2.4 There are three types of glucose monitoring referred to throughout this paper.
- capillary blood glucose monitoring which is the traditional finger prick method of measuring blood glucose levels
- intermittently scanned Glucose Monitoring (isCGM) which is also known as 'flash' monitoring. This is a device worn on the skin that intermittently measures glucose levels and sends the information to the user's smartphone.
- real time Continuous Glucose Monitoring (rtCGM) which is a device worn on the skin that continuously monitors blood glucose levels and sends the information to the user's smartphone.

2.5 A hybrid closed loop system connects the CGM device to the user's insulin pump for automatic dose adjustments. This technology is currently being piloted. See later section in report for more details.

3. Summary of NICE Guidance Recommendations

3.1 **NG17 Type 1 diabetes in adults**. Offer adults with Type 1 diabetes a choice of real-time continuous glucose monitoring (rtCGM) or intermittently scanned continuous glucose monitoring (isCGM) based on their individual preferences, needs, characteristics, and the functionality of the devices available.

3.2 If both types of device are appropriate, the device with the lowest cost that meets the person's identified needs and preferences should be offered. If a person is unable to or does not wish to use any real-time CGM or isCGM device, offer capillary blood glucose monitoring.

3.3 The decision to use real-time CGM or primary care provided glucose monitoring will need to be made by the specialist diabetes services.

3.4 **NG18 Type 1 diabetes in children and young people.** Offer real-time continuous glucose monitoring (CGM) to all children and young people with Type 1 diabetes, alongside education to support children and young people and their families and carers to use it. Offer intermittently scanned CGM (isCGM) to children and young people (aged 4 years and over) with Type 1 diabetes who are unable to use real-time CGM or who express a clear preference for isCGM. If a child or young person is unable to or does not wish to use any real-time CGM or intermittently scanned CGM device, offer capillary blood glucose monitoring.

3.5 **NG28 Type 2 diabetes in adults.** Offer intermittently scanned continuous glucose monitoring (isCGM) to adults with Type 2 diabetes on multiple daily insulin injections (two or more injections per day) if any of the following apply:
- they have recurrent or severe hypoglycaemia
- they have impaired hypoglycaemia awareness
- they have a condition or disability that means they cannot self-monitor their blood glucose by intermittent capillary blood glucose monitoring but could use an isCGM device (or have it scanned for them)
- they would otherwise be advised to self-test at least eight times a day.

3.6 Offer isCGM to adults with insulin-treated Type 2 diabetes who would otherwise need help from a care worker or healthcare professional to monitor their blood glucose.

4. Current CGM availability across Cheshire and Merseyside

4.1 These devices have been available to people with Type 1 diabetes who meet a wide range of criteria that were published by NHS England in 2019. The criteria for children and young people were less stringent and as a result use among children is higher. For people with Type 2 diabetes who are using insulin, isolated requests have been agreed on a case-by-case basis. The update to NG28 will enable many more people with Type 2 diabetes to access CGM and all patients with Type 1 diabetes are now eligible to receive it.

4.2 Latest figures show that in Cheshire and Merseyside, for people with Type 1 diabetes, 72.3% are already using some form of CGM however there is significant variation with the use of isCGM varying between 55% and 83% in different Places. This variation correlates to levels of deprivation. There is also significant variation in prescribing rates between providers.

4.3 Adoption of the new NICE guidance in full within a single Cheshire and Merseyside prescribing policy and implementation in a consistent way, will allow us to closer examine the unwarranted variation across C&M and work with clinicians to ensure best practice is universally adopted and health inequalities reduced.

5. Impact of new NICE recommendations

5.1 **Device Costs.** There will be an increase in numbers of patients eligible for this treatment. Potentially more people with Type 1 diabetes will wish to use secondary care provided CGM and many patients with Type 2 diabetes who meet the criteria will wish to use primary care provided glucose monitoring.

5.2 The Cost per patient per year is outlined below:

Devices prescribed in secondary care (available via the NHS supply chain)

Dexcom G6 CGM	£2,645 ex VAT per year
Medtronic CGM	£3,240 ex VAT per year
FreeStyle Libre 3 CGM	£1,100 ex VAT per year

Devices prescribed in primary care on FP10

FreeStyle Libre 2 Flash glucose monitoring	£910.00 (intermittently scanned)
Dexcom One	£912.50 (real time)
GlucoRx Aidex	£760.50 plus £40 for a transmitter that lasts 4 years (real time).

5.3 NICE provide a resource template for local systems to estimate the costs of implementing new treatments. Once the NICE guidance is approved it will take time for all eligible patients to be commenced on the new treatments therefore the NICE template has considered two scenarios with different rates of implementation over the next five years. For Cheshire and Merseyside, the estimated costs in year five range from £4.2m to £6.1m based on assumptions around current rates of implementation.

5.4 The template assumed a current average use of CGM of 64% of all patients with Type 1 diabetes. More recent discussions with the Cheshire and Merseyside Diabetes Clinical Network have revealed that the current number of adult patients with Type 1 diabetes already using CGM technology are slightly higher than assumed at the time the guidelines were published and the current number of children and young people with Type 1 diabetes already using CGM technology is significantly higher than the March 22 estimates. The overall average currently is 72.3%. The area where we expect to see the greatest increase in uptake is in patients with Type 2 diabetes as there are currently minimal criteria under which this group of patients are eligible for CGM. Using these revised current activity levels would suggest a cost in year five closer to £3.1m.

5.5 In practice, the figures are expected to be even lower than estimated for the following reasons:

- market forces mean manufacturers are starting to abandon traditional glucose monitors and enter the CGM market.
- NICE based the calculations on specific devices available at that time. Since then, further devices have come onto the market at a lower unit cost.
- the new guidance states that the device with the lowest cost that meets the person's identified needs and preferences should be offered. For many people the lower functionality, and therefore cheaper, devices will be sufficient.
- there are potential savings to be made through the establishment of a centralised procurement service which would see the unit price drop by up to 33%.

5.6 **System Capacity.** Specialist diabetes services will be under increased pressure to provide CGM and to see all the adults with Type 1 diabetes who currently use blood glucose testing strips who wish to be assessed for either primary care provided glucose monitoring or secondary care provided CGM. Primary care workload will also increase in terms of queries and actioning of specialist service recommendations.

6. Benefits

6.1 NICE have undertaken extensive economic analysis[4] in coming to their recommendations which included quality of life improvement when the fear of hypoglycaemia is reduced and concluded that these treatments are cost effective. If we consider the population of Cheshire and Merseyside, we can see that there are significant potential benefits in the longer term that offset the increase in annual prescribing costs to the system.

6.2 Hypoglycaemia (very low blood sugar usually as a result of unintentional over medication) has a major impact on the lives of patients; impacting their ability to drive and undertake certain jobs as well as the negative impact on overall wellbeing that fear of hypoglycaemic episodes brings. In C&M over the past 12 months there have been 2,385 hospital admissions with severe hypoglycaemia at an estimated cost of £880k. The NICE evaluation showed that CGM treatments can reduce severe hypoglycaemic episodes by up to 55%.

6.3 Poorly controlled diabetes causes multiple long term adverse outcomes including a higher risk of heart attacks and other cardiovascular events, kidney failure and blindness. The cost to the NHS and society more broadly of managing these complications is significant, as outlined below:

Myocardial infarction	£4,076 year 1 only
Stroke	£4,555 year 1 only
Renal failure requiring dialysis	£33,579 per year
Blindness	£7,570 per year
Peripheral vascular disease **Foot ulcer** **Amputation** **Post amputation care**	 £3,520 per year £8,440 £25,677 per year

6.3 In C&M over the past 12 months 667 diabetic patients underwent an amputation procedure of which 227 were classed as major amputations with a total cost of over £1.9m. The cost to the NHS and social care of looking after patients post major amputation is £25.6k per patient per year.

6.4 Diabetes control is measured using a test called HbA1c which is reported using the mmol/mol unit however until 2011 this was expressed a % figure and this is the unit that all the major diabetes research trials used and is the unit that NICE used in their economic evaluation. Target levels depend on individual circumstances however Table One gives a rough guide.

Table One

Normal	< 6%
Good diabetic control	6-7%
Poor control	8-10%
Very poor control	>10%

[4] www.nice.org.uk/guidance/ng17/evidence/economic-model-report-pdf-9196141213

6.5 The landmark UKPDS[5] and DCCT[6] studies showed a direct correlation between improved control of blood sugar levels and a reduction in complications, with a 1% reduction in a person's HbA1c shown to produce a:

- 14% reduction in heart attacks.
- 21% reduction in deaths
- 37% reduction in microvascular complications (causing blindness and kidney disease)
- 43% reduction in the rate of amputation or death from Peripheral vascular disease.

6.6 The NICE evaluation showed that rtCGM treatment reduced HbA1c by 0.8344% and can therefore be expected to deliver significant reductions in complications with associated cost savings in longer term to offset additional cost of treatment with CGM.

6.7 **The NHS England Hybrid Closed Loop Trial.** In 2021, NHS England offered 1,000 people with Type 1 diabetes the opportunity to pilot a closed loop system with an insulin pump and CGM device that are integrated. Some of these patients are within NHS Cheshire and Merseyside. The results of this pilot will provide evidence to support a NICE technology appraisal (TA) which is expected to be published next year. The pilot is coming to an end and temporary funding arrangements have been put in place by the ICB to enable these patients to continue on this treatment until the NICE TA is published. It is worth noting that commissioners have an obligation to implement NICE TAs once they are approved.

7. Recommendations

7.1 NICE has concluded that real-time CGM (rtCGM) and intermittently scanned CGM (isCGM) are cost-effective use of NHS resource when used in the populations described in this paper. It is therefore recommended that the Board:

- **approves** the recommendation that the current Cheshire & Merseyside CGM policy is retired and;
- **approves** the adoption of the recommendations within NICE NG17, NG18 and NG28.

7.2 Approval of the recommendations will ensure equitable access to CGM and flash glucose monitoring for patients with diabetes across NHS Cheshire and Merseyside.

[5] United Kingdom Prospective Diabetes Study Group: Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with Type 2 diabetes (UKPDS 33). Lancet 352: 837–853, 1998

[6] Diabetes Control and Complications Trial Research Group: The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. New Engl J Med 329:977–986, 199

8. Next steps

8.1 If the Board was to approve these recommendations, to offset some of the financial impact of the adopting the updated guidance all providers need to engage with and implement the setup of a centralised process for ordering. This will enable maximum discounts for bulk ordering to be achieved. This centralised process will enable a more efficient, streamlined process and provide assurance to the ICB that a robust and consistent process is being followed by all providers.

8.2 The Cheshire and Merseyside Area Prescribing Committees and the Diabetes Network will issue guidance to clinicians to support decision making around which specific devices should be prescribed in which settings to ensure maximum value for money.

8.3 The additional costs outlined within this paper are estimated because there is currently no standardised way of monitoring implementation rates. Current costs are managed in a few different ways across C&M with some sitting within block contracts and some in primary care. It is therefore recommended that a task and finish group is established to provide assurance to the ICB Resources committee and the ICB Performance and Quality committee that this area of prescribing is appropriately managed.

8.4 These tasks will be led by the C&M Medicines Optimisation team under the leadership of the ICB Chief pharmacist.

Collaboration at scale to enable better care at Place

Strategic Proposition on the Future Scope of the Cheshire & Merseyside Mental Health, Learning Disability and Community Provider Collaborative

September 2022

NHS Alder Hey Children's NHS Foundation Trust
NHS Bridgewater Community Healthcare NHS Foundation Trust
NHS Cheshire and Wirral Partnership NHS Foundation Trust
NHS Countess of Chester Hospital NHS Foundation Trust
NHS East Cheshire NHS Trust
NHS Mersey Care NHS Foundation Trust
NHS Mid Cheshire Hospitals NHS Foundation Trust
NHS St Helens and Knowsley Teaching Hospitals NHS Trust
NHS Wirral Community Health and Care NHS Foundation Trust

Who we are

- All NHS providers of Mental Health, LD and Community services
- Combined budget of over £1.5 bn
- 20,000 staff
- Multiple partners
- Multi-Place contracts
- 3 specialist Mental Health LPCs with combined budgets of £94m
- Meeting the needs of people with complex multiple physical and mental health conditions in their homes and communities

PURPOSE:

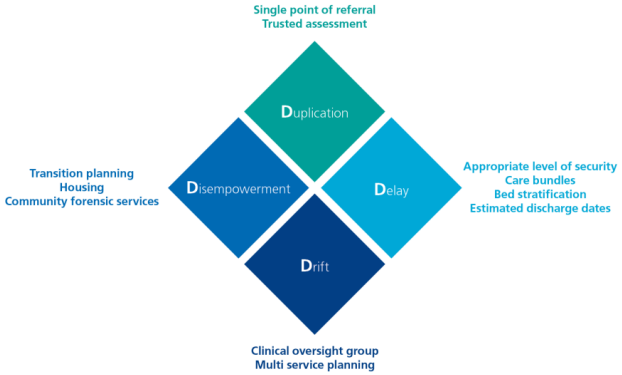
We are a collaborative of NHS providers pursuing equitable, sustainable, connected physical and mental health services that deliver improved health and wellbeing for people in their communities. Founded upon a principle of subsidiarity, we do this at Place across the whole of Cheshire and Merseyside, in partnership with local communities and a wide range of agencies.

MISSION:

We will work together with the people we serve, and all partners to commission and provide a population health focused approach to delivering connected MH, LD and Community Services. We will use our scale, breadth and diversity of expertise to offer high quality levels of service across Places, to improve outcomes and equity of care. Our alliance will provide a sound platform to engage and motivate our workforce and ensure the best possible value for investment across the system.

NHS Alder Hey Children's NHS Foundation Trust
NHS Bridgewater Community Healthcare NHS Foundation Trust
NHS Cheshire and Wirral Partnership NHS Foundation Trust
NHS Countess of Chester Hospital NHS Foundation Trust
NHS East Cheshire NHS Trust
NHS Mersey Care NHS Foundation Trust
NHS Mid Cheshire Hospitals NHS Foundation Trust
NHS St Helens and Knowsley Teaching Hospitals NHS Trust
NHS Wirral Community Health and Care NHS Foundation Trust

Collaboratives in Action – Prospect LPC Achievements



Co-produced and agreed clinical model

Embedded collaborative working to effectively utilise the Partnership's resources as a single stock

- Agreed standard access assessment
- MSU and LSU referrals admission panel
- Reduction in waiting list numbers
- Reduction of patients placed outside Cheshire and Merseyside
- Targeted work with patients with long lengths of stay to support pathway out of secure care
- Clinical Oversight Group – senior clinicians across the Partnership working collaboratively with more complex patients

Directing resources from the traditional bed base into new service developments

- Prison Pathway Team
- Specialist Community Forensic Team (SCFT)
- Learning Disability and Autism Community Forensic Team – joint commissioning opportunity with the Transforming Care Partnership
- Autism specific in-patient service pilot

Collaboration at scale to enable better care at Place

The proposition

To take delegated responsibilities and budgets from the ICB, to become the Convenor of the System at Scale, reducing unwarranted variation, improving equity in care delivery and outcomes, improving productivity and value for money.

The Collaborative will provide a way to structure the complexity of multiple partners across multiple Places and will:

- Be a strong and single voice.
- Develop cross pathway transformation
- Fund and deliver services
- Sustain small and fragile services
- Ensure consistency of provision
- Reduce the outcome gap

The Collaborative will use a population health approach and will focus on the following priorities;

1. Identifying and reducing unwarranted variation in service delivery
2. Fully integrating the Mental Health Programme into the Collaborative focusing on improving access
3. Developing the NHS@Home offer, based on the rollout of Virtual Wards
4. Working with Places to develop a consistent offer for Frailty and Complex Lives
5. Developing a shared financial strategy and workforce plan

Alder Hey Children's NHS Foundation Trust | Bridgewater Community Healthcare NHS Foundation Trust | Cheshire and Wirral Partnership NHS Foundation Trust | Countess of Chester Hospital NHS Foundation Trust | East Cheshire NHS Trust | Mersey Care NHS Foundation Trust | Mid Cheshire Hospitals NHS Foundation Trust | St Helens and Knowsley Teaching Hospitals NHS Trust | Wirral Community Health and Care NHS Foundation Trust

Added value of our proposition

What we are doing now

- Designing and delivering new service models (Seacole, Oximetry at home, Covid treatments, UTC model)
- Reduce variation – Community Waiting lists, IV Therapy, Mental Health access across the pathway
- Emergency response – escalation & mutual aid
- Improving workforce flexibility
- Leading System-wide Programmes e.g. System P, Mental Health Programme
- Improving capacity utilisation
- Sharing best practice
- Strengthening our collective intelligence (CIPHA)

Where our proposition will add value

- Ability to target resources to the areas that best meet Place priorities, including Primary Care & Third Sector
- Shared financial risk
- Coordinated investment in Technology-enabled Care
- Strategic approach to investment in Mental Health & Community Services
- Ability to develop a more integrated health and care workforce at neighbourhood, Place and *where appropriate* beyond place
- Sustainable commissioning of small and/or fragile services (fragile services can be big e.g. secure MI but fragile because of skills base)
- Consistently commissioned service standards, access and outcomes

Alder Hey Children's NHS Foundation Trust | Bridgewater Community Healthcare NHS Foundation Trust | Cheshire and Wirral Partnership NHS Foundation Trust | Countess of Chester Hospital NHS Foundation Trust | East Cheshire NHS Trust | Mersey Care NHS Foundation Trust | Mid Cheshire Hospitals NHS Foundation Trust | St Helens and Knowsley Teaching Hospitals NHS Trust | Wirral Community Health and Care NHS Foundation Trust

Supporting ICS objectives

improve outcomes in health and healthcare

- Consistent service frameworks and Clinical standards
- Share best practice across providers and places to improve effectiveness, quality and risk management
- Invest in innovation / R&D
- Support acute effectiveness: stem the front door & unlock the back door
- Workforce wellbeing, flexibility, resilience, fitness for the future

Tackle inequalities in outcomes, experience and access

- Target areas of unwarranted variation
- Share performance and outcomes data & provide supportive challenge
- Shift focus to population segments & target challenged communities / populations
- Investment strategy based on levelling up
- Consistent approach to supporting Primary Care and the Care Sector

Enhance productivity and VFM

- Collective approach to / shared CIPs
- Allocative efficiencies
- Collective investment plan & shared bids for new monies,
- Financial risk distributed across the system
- Consistent & transparent cost model resulting from mutual trust, respect and challenge
- Shared workforce planning and design of new roles
- Shared transactional support services – leverage scale to increase process automation

Support broader social and economic development

- Collaborative approach to local sourcing (employment and procurement)
- Maximise the use of shared estate and assets
- Build on Anchor institutions in local communities
- Utilise and develop local voluntary services

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NHS Mid Cheshire Hospitals NHS Foundation Trust
NHS St Helens and Knowsley Teaching Hospitals NHS Trust
NHS Wirral Community Health and Care NHS Foundation Trust

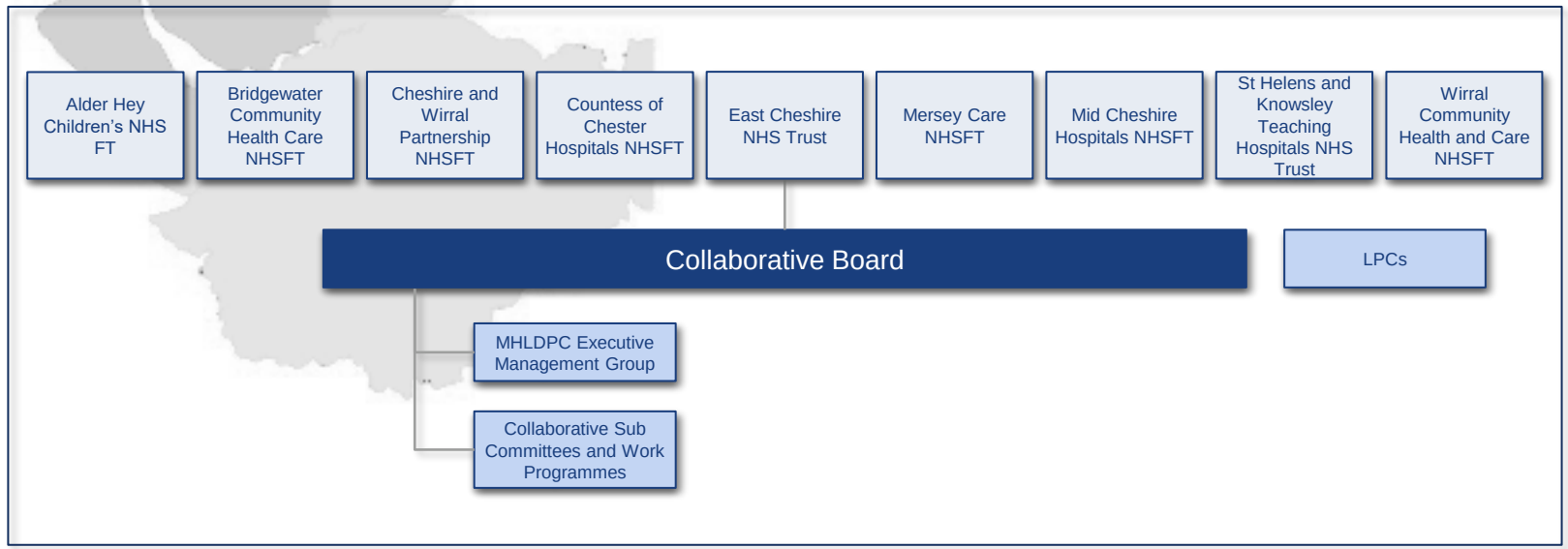
Governance

The Collaborative will build on its existing structure with the establishment of a formal s65Z6 Joint Committee across all member organisations. With Mersey Care in the role of "banker", this Committee will be the Collaborative Board, enabling collective and rapid decision making and serving as a platform for any risk share arrangements.

We will draw on the experience of the existing specialist Mental Health Lead Provider Collaboratives for Forensics, Tier 4 CAMHS and Eating Disorders to establish effective partnerships, robust financial and transaction governance, risk management and assurance.

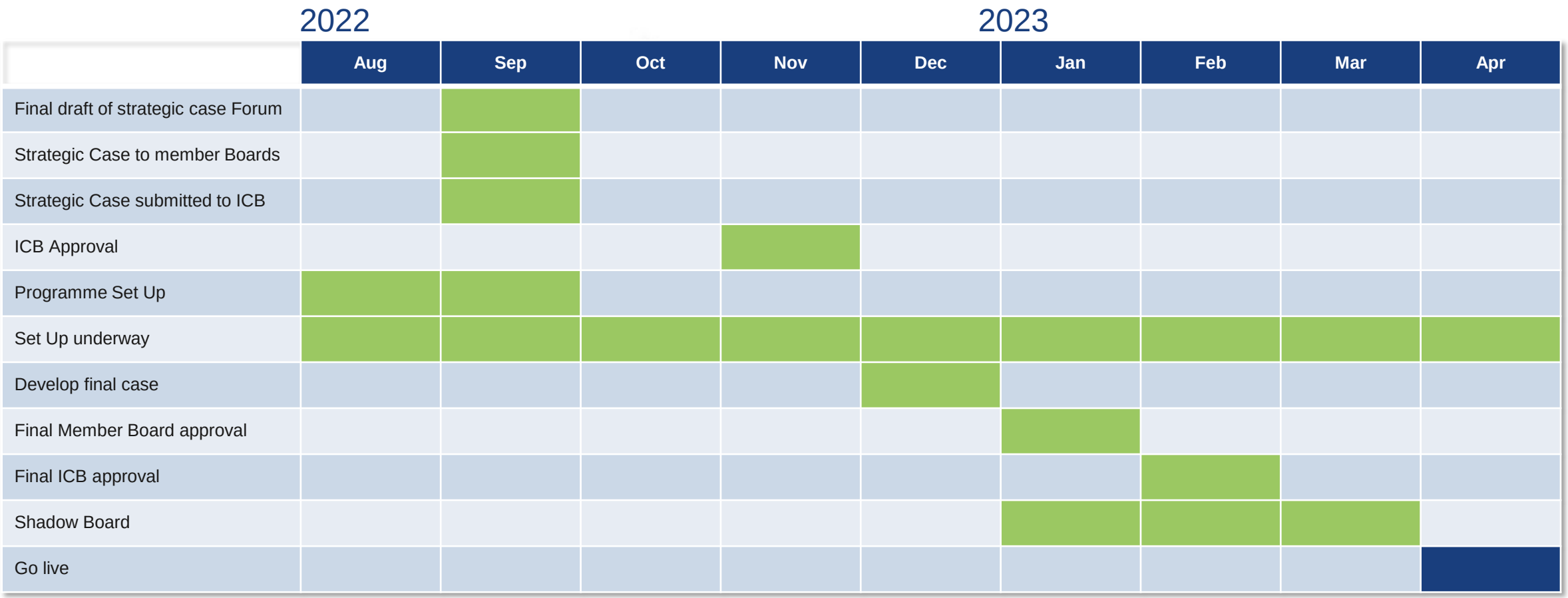
Collaborative Board Membership will comprise:

- Chief Executives of member organisations
- 2 Local Authority Members
- 1 Voluntary Sector Member
- 1 PCN Member
- 3 – 5 non-Executive Members
- The Chair and Vice Chair roles will come from the non- Executive group and will not be aligned with Mersey Care. Could be independent of any member Trust.



Alder Hey Children's NHS Foundation Trust · Bridgewater Community Healthcare NHS Foundation Trust · Cheshire and Wirral Partnership NHS Foundation Trust · Countess of Chester Hospital NHS Foundation Trust · East Cheshire NHS Trust · Mersey Care NHS Foundation Trust · Mid Cheshire Hospitals NHS Foundation Trust · St Helens and Knowsley Teaching Hospitals NHS Trust · Wirral Community Health and Care NHS Foundation Trust

Timetable 22/23

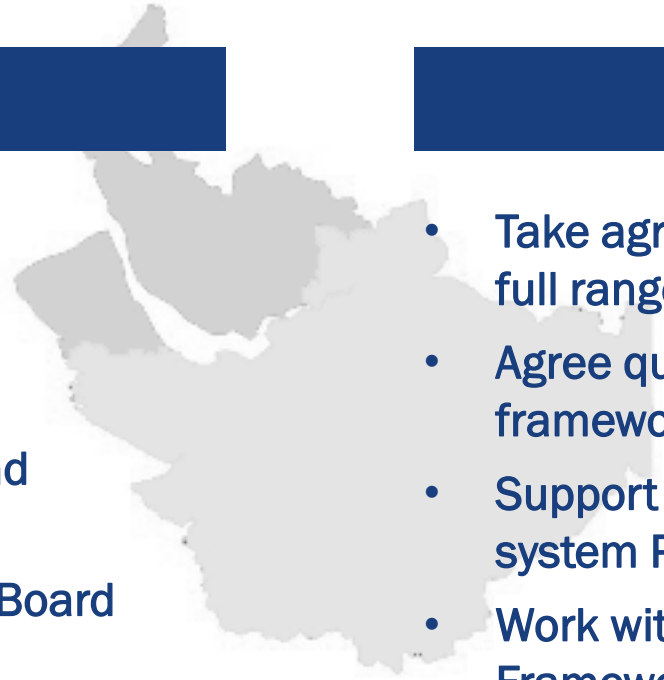


Timetable 23/25

With a phased approach in subsequent years.

2023/24

- MHLDPC benchmarking
- Contract due diligence
- Develop contracting model
- Develop Commissioning Governance and Infrastructure
- Develop and operate as a Collaborative Board
- Full delegation of MH (and LD) budgets



2024/25

- Take agreed delegated Commissioning budgets for full range of services
- Agree quality outcome and financial performance framework
- Support Place based strategy and planning through system P
- Work within agreed Accountability and Performance Framework

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

27 October 2022

System Financial Assurance Update

Agenda Item No	**ICB/10/22/13**
Report author & contact details	Claire.Wilson@cheshireandmerseyside.nhs.uk Director of Finance
Report approved by (sponsoring Director)	Claire Wilson Director of Finance
Responsible Officer to take actions forward	Claire Wilson Director of Finance

Cheshire and Merseyside ICB Board Meeting

NHS Cheshire and Merseyside

System Financial Assurance Update

Executive Summary	The NHS is managing a number well understood operational and financial challenges as we recover from COVID, prepare for winter and manage rising costs of inflation. The finance report, elsewhere on the Board agenda, sets out how these challenges are translating to financial risk in the delivery of our financial plans. At its last meeting, the Integrated Care Board (ICB) asked for an update on the arrangements in place to support financial delivery and assurance in delivering our financial commitments. This paper sets out the current and emerging arrangements on this.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X		X		
Recommendation	**The Board is asked to:** • Note the contents of the report and provide any feedback into the development of the financial accountability framework going forward.				
Key issues	Paper sets out arrangements for financial assurance to support delivery of financial plan.				
Key risks	Paper sets out mitigations and controls against the risk to delivery of financial plan and to future financial sustainability of our system.				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	X				
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
				X	
Route to this meeting	*n/a*				
Management of Conflicts of Interest	n/a				
Patient and Public Engagement	n/a				
Next Steps	Further updates will be provided as local and national policy emerges as indicated in the paper				
Appendices	Appendix A - Cheshire and Merseyside Financial Principles 2022/23				

System Financial Assurance Update

1. Background

1.1 The NHS is managing a number well understood operational and financial challenges as we recover from COVID, prepare for winter and manage rising costs of inflation. The finance report, elsewhere on the Board agenda, sets out how these challenges are translating to financial risk in the delivery of our financial plans.

1.2 At its last meeting, the Integrated Care Board (ICB) asked for an update on the arrangements in place to support financial delivery and assurance in delivering our financial commitments. This paper sets out the current and emerging arrangements on this and the Board are asked to provide any feedback into the development of the financial accountability framework going forward.

2. Development of financial plans

2.1 System partners across Cheshire and Merseyside worked closely together to develop operational and financial plans which were aligned, supported our ambitious system plans and delivered on national requirements.

2.2 The financial planning element of this work was supported through the following assurance processes coordinated by the ICS:

- Financial principles agreed amongst Finance Directors (See Appendix A)
- Triangulation of workforce, activity and financial planning assumptions through joint HR Directors, Finance Directors and Operational Director discussions.
- Common set of assumptions agreed between commissioners and providers on income, inflation and other cost pressures.
- Detailed review of individual organisations financial plans using bridging analysis of expenditure movement over the last 3 years. Fully transparency and open book policy between all system partners to enable consistency and challenge where appropriate.
- Multidisciplinary peer review plan review meetings chaired by ICB clinician involving Executive members from ICB and Trust where organisation has a deficit plan. Each meeting was supported by system peer CEO, Local Authority officers and Place Director.
- System wide capital prioritisation panel, chaired by ICS CFO with representation from clinical leaders, Estates officers and provider collaboratives.

3. In year financial performance

3.1 The ICS consolidates the system wide NHS financial position each month, including performance against plan, Cost Improvement Plan (CIP) delivery, capital, workforce and cash. This is reported to the Board and Finance, Investment and Resources Committee each month. Gross financial risks and mitigations are also collected from each organisation and net risk is a key indicator reported to the Board.

3.2 The sections below set out the financial grip, assurance and support arrangements currently in place:

Financial Governance. Each organisation has been asked to complete a self-assessment against the national Financial Sustainability Control Checklist to enable areas for improvement to be identified. This checklist has been developed by the Healthcare Financial Management Association (HFMA) and sets out the components of strong financial management and governance. Results will be independently audited by MIAA. It is anticipated that this exercise will help us identify collective areas for improvement and sharing of best practice across the system as well as being a tool for individual organisations to review financial governance arrangements if required.

In year financial assurance and escalation. The ICS CFO meets regularly with each organisation to discuss financial performance and risks. Where an individual organisation reports an adverse variance to plan several escalation actions will be triggered:

- Financial assurance meetings with Trust CEO and CFO chaired by the ICS CEO which focuses on actions being taken to recover the position and how system partners can support this. These meetings are supported by a peer CEO and ICB place director.
- ICS led deep dive into financial position, balance sheet, cash, investment review.
- Discussion of any additional support required – recent examples have included secondment of additional staff to support CIP delivery for example.
- Focussed work on identifying drivers of the deficit in one Trust being piloted
- Consideration of external financial review to help identify recommendations for improvement e.g. LUFHT.

It is obviously important for financial performance to be considered alongside quality and operational performance for each organisation. This triangulation is currently supported through the interdisciplinary reviews we have undertaken in planning and delivery meetings to date. Further work is planned to integrate our reporting processes to provide a holistic view of performance and assurance.

Adverse changes to forecast
NHS England are developing the protocol to be followed where an organisation is considering changing its forecast to report an adverse variance to plan. Further updates will be provided to the Board as these arrangements are finalised. It is likely that additional controls and national reporting arrangements will be required by those organisations. Single Oversight Framework (SOF) ratings may also be reviewed.

NHS England have recently published its new operating model which includes how performance management arrangements will work between ICB, Region and National NHSE teams. We will work with NHS England to develop our in-year monitoring and support processes in line with this emerging policy.

Development of financial accountability framework. A CEO workshop is arranged for the 18th of November 2022 where the system wide financial accountability framework will be developed further with NHS partners. This workshop will also look to confirm the key efficiency workstreams. Key outputs from the session will be shared with Chairs and Non-Executive Directors in their workshop in November 2022.

4. Financial strategy

4.1 The ICS will be developing its overall system strategy over the next 6 months, and it is critical that our financial strategy underpins and supports our ambitious system plans alongside delivering financial sustainability over the longer term.

4.2 National guidance is expected in late December 2022 which sets out the long-term planning commitments, financial framework and system allocations for the next 3 – 5 years. We will work with our system partners to develop a comprehensive medium-term financial plan for our system in line with national timeframes before the end of the financial year.

4.3 As part of this, we will consider:

- Allocation strategy to support reduction in inequalities
- Financial mechanisms to support health and care integration
- System wide finance regime and funds flow
- Key productivity and efficiency opportunities
- System wide estates and capital requirements
- How we provide the headroom to support transformational change

4.4 Further updates on our approach to developing the financial strategy will be provided to the Board as the national financial landscape becomes clearer.

5. Recommendations

5.1 The Board is asked to note the current and emerging arrangements to support in year financial delivery and provide any feedback into the development of the financial accountability framework going forward.

Appendix A

Cheshire and Merseyside Financial Principles 2022/23

- Improving our population health, reducing health inequalities, and improving quality of care will be at the core of everything we do.
- Commitment to transparent and honest data and information sharing between all partners in system. This will enable objective, evidence-based decision making.
- The financial framework will be developed to:
  - Incentivise delivery of operational performance and reflect an appropriate transfer of resources to support mutual aid.
  - Incentivise integrated care and improved population health outcomes.
  - Incentivise and support service transformation as we recover from the pandemic.
- The finance regime will align decision making and accountability.
- Each organisation will commit to, and be held accountable for, delivery of its financial targets, including efficiency requirements, whilst ensuring safe, high-quality care is maintained.
- Partners will develop risk and reward share agreements which support collective decision making.
- There is a commitment to deliver financial balance across the system - Individual organisations work towards a financially sustainable underlying financial position in support of this.
- Work to understand the C&M system deficit will be jointly understood and component parts managed as follows:
  - Operational inefficiencies to be addressed by organisation.
  - Strategic inefficiencies to be considered by system for support.
  - Structural inefficiencies quantified and considered in long term planning.

- All partners are committed to collaborate at scale where clear benefits are demonstrated. E.g. collaboration of corporate services.
- To maximise our impact on the significant health inequalities across our system, partners will work together to take advantage of opportunities for additional resources and to identify and secure inward investment.
- Transactions between partners will be as streamlined and simple as possible, minimising any administrative burden or perverse incentives.
- Conflicts of interest between partners to be managed openly and appropriately and in accordance with agreed processes.
- Nolan principles of public office will be upheld by all system leaders [selflessness; integrity; objectivity; accountability; openness; honesty; leadership]

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

27 October 2022

Winter Planning 2022/23

Agenda Item No	**ICB/10/22/14**
Report author & contact details	Andy Thomas, Associate Director of Planning
Report approved by (sponsoring Director)	Anthony Middleton, Director of Performance and Planning
Responsible Officer to take actions forward	Andy Thomas, Associate Director of Planning

Cheshire and Merseyside ICB Board Meeting

Winter Planning 2022/23

Executive Summary	• **PR1929 Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter** was issued 12 August 2022, setting out the national operational context and high-level expectations for winter 2022/23. • The ICB is accountable for ensuring that the Cheshire and Merseyside (C&M) system providers and other partners deliver their agreed role in their local plans and work together effectively for the benefit of the local population. • An NHS C&M Winter Planning Operational Group (WPOG) has been set up bringing together colleagues from across C&M, including representatives from Place and Provider Collaboratives, as well as key regional partners, North West Ambulance Service and NHS England. This group has overseen the production of the first formal iteration of the checklists and assurance framework that were issued alongside the national guidance. This was submitted on 26 September 2022. • Further national guidance has been issued on 18 October 2022 under the banner **'Going further on our winter resilience plans'**. The response to this will be coordinated via the WPOG and an updated position will be reported to the Board in due course.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X		X		
Recommendation	**The Board is asked to:** • **note** the contents of this report for information • **support** the recommendation that an updated position is reported to the Board after the work in response to **PR2090 Going further on our winter resilience plans**				
Key issues	As per executive summary				
Key risks	Based on the most current winter plan submissions, key system risks are as follows: • Workforce, encompassing recruitment, retention (better wages available in other sectors), skill mix/shortages, gaps in rotas, sickness etc. These issues are apparent across medical, nursing, AHPs, ambulance service, and social are including domiciliary care • Significant risk to elective programme, diagnostics, cancer backlog • Readiness/completeness of Directories of Service to increase alternatives to conveyance to ED • UTCs/ability/capacity for streaming to primary care services • Discharge, ability to reduce proportion of patients not meeting criteria to reside in hospital • Confidence of clinicians to refer into admission avoidance and step-down services such as Virtual Wards • Communications plans for Winter – extent to which public can be informed and engaged in helping the system to navigate winter pressures.				

Cheshire and Merseyside ICB Board Meeting

Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**
	X	X	X	X
	Legal	**Health Inequalities**	**EDI**	**Sustainability**
		X		X
Route to this meeting	NHS England Winter Planning Guidance, and the ICB's response to it, have been discussed at the Executive Team Meeting in August and September, and at regular meetings of the Winter Planning Operational Group chaired by the Director of Performance & Planning. This group has coordinated the required ICB outputs in response to the national guidance in line with NHS England's deadlines.			
Management of Conflicts of Interest	*n/a*			
Patient and Public Engagement	*n/a*			
Next Steps	It is envisaged that a further paper will be submitted to the Board for information once the next iteration of the winter planning process is undertaken in response to the letter dated 18 October 2022. The Executive Team Meeting will continue to receive updates from the Winter Planning Operational Group and monitor progress on implementation of winter plans as required.			

Winter Planning 2022/23

1. Executive Summary

1.1 ***PR1929 Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter***[1] was issued 12 August 2022, setting out the national operational context and high-level expectations for winter 2022/23.

1.2 The Integrated Care Board (ICB) is accountable for ensuring that Cheshire and Merseyside (C&M) system providers and other partners deliver their agreed role in their local plans and work together effectively for the benefit of the local population.

1.3 An NHS C&M Winter Planning Operational Group (WPOG) has been set up bringing together colleagues from across C&M, including representatives from Place and Provider Collaboratives, as well as key regional partners, North West Ambulance Service (NWAS) and NHS England. This group has overseen the production of the first formal iteration of the checklists and assurance framework that were issued alongside the national guidance. This was submitted on 26 September 2022.

1.4 Further national guidance was issued on 18 October 2022, under the banner ***PR2090 Going further on our winter resilience plans***.[2] This significantly extends the scope of the winter actions required from ICBs. The response to this will be coordinated via the WPOG and an updated position will be reported to the Board in due course.

2. Background

2.1 It is recognised that the operational context is extremely challenging. Urgent and Emergency Care remains under significant pressure.

2.2 Acute bed occupancy is 2-3% higher than last year, with the majority of acute hospitals in Cheshire & Merseyside regularly reporting occupancy in a range from 97-100% occupancy.

2.3 More than 1000 beds, approximately 23% of general acute bed stock, are occupied by patients no longer meeting the criteria to reside.

2.4 The social care market is fragile due to a mix of factors including demand, transient workforce, cost of living increase, and Covid-19.

2.5 The NHS can anticipate additional respiratory challenges due to flu.

2.6 Resources remain constrained. There are unlikely to be additional funds available for winter, other than those already notified.

[1] https://www.england.nhs.uk/next-steps-in-increasing-capacity-and-operational-resilience-in-urgent-and-emergency-care-ahead-of-winter/
[2] https://www.england.nhs.uk/publication/going-further-on-our-winter-resilience-plans/

3. Winter Planning – National Guidance and Objectives

3.1 PR1929 *Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter* issued 12 August 2022. This set out the operational context and the high-level expectations for winter 2022/23.

3.2 Core national objectives and actions are to:

- prepare for variants of COVID-19 and respiratory challenges, including an integrated COVID-19 and flu vaccination programme.
- increase capacity outside acute trusts, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.
- increase resilience in NHS 111 and 999 services, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.
- Target Category 2 response times and ambulance handover delays, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
- reduce crowding in A&E departments and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.
- reduce hospital occupancy, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
- ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100-day challenge'.
- provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

3.3 NHS England has identified the following six specific metrics, key to the provision of safe and effective urgent and emergency care, that will be used to monitor performance over winter:

- 111 call abandonment.
- mean 999 call answering times.
- Category 2 ambulance response times.
- average hours lost to ambulance handover delays per day.
- adult general and acute type 1 bed occupancy (adjusted for void beds).
- percentage of beds occupied by patients who no longer meet the criteria to reside.

3.4 **Accountability.** The ICB is accountable for ensuring that C&M system providers and other partners deliver their agreed role in their local plans and work together effectively for the benefit of the local population.

3.5 NHS C&M is therefore responsible for initial problem solving and intervention should providers fail, or be unable, to deliver their agreed role, drawing on intervention and support from NHS England regional teams as required.

3.6 NHS England NW region's role is to stress test our plans and to 'check and challenge' progress in delivering them.

3.7 On performance metrics, the overall objective remains the provision of safe and effective care. Until the adoption of the Clinically led Review of Standards is agreed with the Government, current standards remain for emergency department performance and flow. Likewise, objectives set out in Planning

3.8 Guidance, which includes reducing 12 hour waits and increased clinical input in 111, remain. In addition, NHS England has identified the six specific metrics above.

3.9 **Key Actions and Timelines.** Alongside the national guidance, NHS England issued a winter assurance framework comprising several winter planning templates for completion at ICB level, which consisted of:

- **Demand & Capacity Assurance:** In response to agreed bids to expand bed capacity, (see below), ICBs were to agree the monitoring mechanism by the end of August 2022 and report progress monthly thereafter
- **Urgent Emergency Care Action Plan (UEC):** C&M level return submitted 26/09, informed by Place level returns sitting behind. These have also been shared with region for assurance purposes. It was intended that this would be updated and collected monthly.
- **Operational Self-Assessment Good Practice Checklist:** C&M level return submitted 26/09, with Provider level self-assessments sitting behind
- **Good Practice Checklist:** Library of good practice. Optional, for local use.

When	What
12/08	***PR1929 Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter*** issued
Mid-late August	C&M approach to winter planning socialised via ICB execs meeting, with Trusts via COO network
26/08	Initial request to Places to complete first Place level cut of plans using national templates, in advance of first C&M Winter Planning Operational group
31/08	C&M submitted intended approach to monitoring of demand and capacity schemes to region
05/09	C&M submitted confirmed monitoring including profiling of implementation and spend
07/09	Inaugural C&M Winter Planning Operational Group held, review of first cut of plans
12/09	2nd iteration of Place plans and checklists
19/09	3rd iteration of Place plans and checklists
26/09	Submission of: Demand & Capacity Return for September C&M ICB Level UEC Action Plan Collated Operational Self-Assessment Good Practice Checklist
07/10	Northwest Winter Conference held, sharing key initiatives/good practice to support response to winter pressures
18/10	***PR2090 Going further on our winter resilience*** plans issued
31/10	National initiation of daily winter battle rhythm and reporting
04/11	Submission of response to second national letter

3.10 **C&M Governance.** The NHS C&M Winter Planning Operational Group was set up and the first meeting held on 07 September 2022, bringing together colleagues from across NHS Cheshire & Merseyside, including representatives from Place and Provider Collaboratives, as well as key regional partners, NWAS and NHS England. The purpose of the group is to ensure a coordinated local approach to winter planning, assurance and delivery in response to the national winter letter and associated guidance outlined above.

3.11 The group is responsible for:

- coordinating the C&M approach to the 2022/2023 winter planning process.
- developing and delivering a work programme that meets the requirements and deadlines set out in the winter planning guidance.
- undertaking C&M wide assurance of plans of submission to NHS England regional/national teams.
- ensuring there is a common approach to delivery of plans and that there are robust arrangements for delivery.
- identifying, managing and escalating risks that relate to the winter planning process itself and delivery risks for winter itself.
- enabling common messages to be shared with colleagues across C&M.
- ensuring co-ordination of winter communications between NHS Cheshire & Merseyside and the NHS England Northwest region.

3.12 The focus is on ensuring a consistent approach (informed by the national UEC assurance framework) to winter planning across the NHS in Cheshire & Merseyside and with key local and regional stakeholders.

3.13 In addition, the ICB has identified a Place level ‘best practice checklist’ for admission avoidance and discharge and has held a series of Place focused meetings to stress test plans.

3.14 It is recognised that some individual organisations may be involved in more than one Place for specific elements of planning, based on existing flows of UEC activity, and that place and provider collaborative leads will collaborate as necessary. These flows in some instances are outside the ICB geography altogether, e.g., into Greater Manchester or Wales.

3.15 **Demand and Capacity.** Prior to the issuing of the winter letter in August 2022, NHS England had invited bids from Trusts in June 2022, for plans to increase bed capacity over winter, with a focus on G&A bed capacity.

3.16 These bids were subject to a regional and national assurance process and during July and August 2022 resulted in the following for C&M (Table One):

Table One

			Trajectory (av. beds per day over month) additional beds over plan					
Trust	**Description**	**Scheme Cost £'s**	Oct	Nov	Dec	Jan	Feb	Mar
Alder Hey Children's NHS Foundation Trust	10 G&A beds (paediatric)	560,000	0	0	10	10	10	10
Countess of Chester NHS Foundation Trust	28 G&A beds	1,062,530	14	28	28	28	28	28
East Cheshire NHS Trust	13 Community beds	474,501	13	13	13	13	13	13
Liverpool University Hospitals NHS Foundation Trust	21 G&A beds at Broadgreen plus D2A	2,400,000	14	27	27	27	27	27
Mid-Cheshire Hospital NHS Foundation Trust	8 G&A beds	320,000	8	8	8	8	8	8
Mid-Cheshire Hospital NHS Foundation Trust	27 Care home beds	1,070,723	27	27	27	27	27	27
Southport and Ormskirk Hospital NHS Trust	14 Community rehab beds	960,000	0	14	14	14	14	14
St Helens and Knowsley Teaching Hospitals NHS Trust	38 Community beds	2,500,000	0	0	0	38	38	38
Warrington and Halton Hospitals NHS Foundation Trust	20 G&A beds	2,393,326	0	20	20	20	20	20
Wirral University Teaching Hospital NHS Foundation Trust	20 G&A beds	1,980,000	0	0	20	20	20	20
		13,721,080	**76**	**137**	**167**	**205**	**205**	**205**

3.17 It is anticipated that all beds planned for delivery in October will be stood up, and implementation has been accelerated by some providers, with Countess of Chester opening all 28 beds in October 2022, and Warrington and Halton bringing forward the opening of its 20 beds from November to October 2022.

3.18 **Key risk and issues:** Based on the submissions collated and returned at the end of September 2022, and current intelligence from systems, the most salient risks and issues are as follows:

- workforce, encompassing recruitment, retention (better wages available in other sectors), skill mix/shortages, gaps in rotas, sickness etc. These issues are apparent across medical, nursing, AHPs, ambulance service, and social care including domiciliary care
- significant risk to elective programme, diagnostics, cancer backlog
- readiness/completeness of Directories of Service to increase alternatives to conveyance to ED
- UTCs/ability/capacity for streaming to primary care services
- discharge, ability to reduce proportion of patients not meeting criteria to reside in hospital

- confidence of clinicians to refer into admission avoidance and step-down services such as Virtual Wards
- communications plans for Winter – extent to which public can be informed and engaged in helping the system to navigate winter pressures.

3.19 ***PR2090 Going further on our winter resilience plans*** was issued 18 October 2022. It references current operational pressures, noting that 'we therefore all need to be prepared for things to get even tougher over the coming weeks and months', and calls for significant expansion of the system winter response as follows:

- **Falls:** Systems to have a community-based falls response service for people who have fallen at home including care homes. To be in place by 31 December 2022, 8am-8pm 7 days per week.
- **Virtual Wards:** Maximise use of virtual wards and consider an Acute Respiratory Infection (ARI) hub to support same day assessment. ICBs should ensure that VWs are effectively utilised both in terms of addressing the right patient cohort and optimising referrals.
- **Support to Care Homes:** Provide additional support for care homes to reduce unwarranted variation in ambulance conveyance rates, working with care homes to identify and access alternative interventions and sources of support
- **Bed capacity:** Maximise use of physical and virtual ward capacity, including delivery of additional beds including previously moth-balled beds
- **System Control Centres:** All systems to set up a 24/7 System Control Centre (SCC). SCCs will balance the risk across acute sector, community, mental health, and social care services to ensure clinical risk is appropriately dispersed across the whole ICS during periods of surge. SCCs will need to be supported by senior operational and clinical decision-makers to proactively manage clinical risk in a 24/7 format for 365 days per year. Systems are to develop their operating model for approval and ensure their SCC is operational by 1 December 2022.
- **Oversight and incident management arrangements:** National desktop exercise on winter pressures and escalation planned for November, led by regions working with ICBs. Seven-day reporting against the UEC sitrep will start from Monday 31 October. Arrangements for the COVID-19 sitrep remain unchanged.
- **Discharge:** In addition to maintaining focus on the high impact actions from the 100-day challenge, more details about distribution of the £500m fund to support social care are to be shared imminently.
- **Elective Activity:** Emphasis on continued grip across both long waits and cancer. All elective procedures to go ahead unless there are clear patient safety reasons for postponing activity. If individual Trusts/ICBs are considering cancelling significant levels of elective care this must be escalated to Regional Director for support and mobilisation of mutual aid where possible.
- **Cancer:** Priority actions on cancer are:
  - Faecal Immunochemical Testing (FIT) in the Lower GI pathway
  - Best Practice Timed Pathway for prostate cancer including the use of mpMRI
  - Tele-dermatology in the suspected skin cancer pathway

  - Greater prioritisation of diagnostic and surgical capacity for suspected cancer.
- **Infection prevention and control (IPC) measures and testing:** Existing UKHSA guidance on the management of COVID-19 patients remains in place, along with the measures detailed in the IPC Manual. Ahead of winter, providers should self-assess their compliance using the IPC board assurance framework. Symptomatic testing is continuing for patients and staff, based on the current list of symptoms.
- **Staff vaccination:** Health and social care workers should receive both the COVID-19 and flu vaccines to protect themselves and their patients. All frontline healthcare workers should be offered both vaccines by their employer.
- **Vaccine uptake:** Systems should continue to look at sections of their community where vaccine uptake is lower and focus significant efforts with partners to ensure community-based support is provided, building on approaches that have proved successful in the past

4. Recommendations

4.1 The Board is asked to:

- **note** the contents of this report for information
- **support** the recommendation that an updated position is reported to the Board after the work in response to **PR2090 Going further on our winter resilience plans**

5. Officer contact details for more information

Anthony Middleton, Director of Performance & Planning
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Andy Thomas, Associate Director of Planning
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NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the Remuneration Committee Chair

27 October 2022

Agenda Item No	**ICB/10/22/15**
Report author & contact details	Matthew Cunningham, matthew.cunningham@nhs.net
Report approved by (sponsoring Director/ Chair)	Tony Foy, Chair of the Remuneration Committee
Responsible Officer(s) to take actions forward	Chris Samosa, Chief People Officer Matthew Cunningham, Associate Director of Corporate Affairs and Governance

Report of the Remuneration Committee Chair

Executive Summary	The Remuneration Committee of the NHS Cheshire and Merseyside Integrated Care Board met on 28 September 2022 and 13 October 2022. Both meetings were quorate and able to undertake the business of the Committee. Declarations of interest noted where applicable. Main items considered at the meetings included: • Committee Terms of Reference (September and October) • Update on Partner Member remuneration update • National award for VSM pay update. The meeting of the 13 October 2022 also considered confidential, employee specific matters. The next meeting of the Committee is scheduled to be held on 20 December 2022.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X	X			
Recommendation	**The Board is asked to:** • **note** the items covered by the Remuneration Committee • **approve** the recommendation to agree the proposed amendments to the Terms of Reference of the ICB Remuneration Committee (Appendix A).				
Impact (x) *(further detail to be provided in body of paper)*	**Financial**	**IM &T**	**Workforce**	**Estate**	
	X		X		
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
	X				
Management of Conflicts of Interest	Declarations of interest noted where applicable at both meetings. Members of the ICB and its regular attendees drawn from the ICB Executive Team are impacted by the decision undertaken at the September 2022 Remuneration Committee regarding VSM Pay.				
Next Steps	Following consideration of this paper and if approvals against the recommendations are provided by the Board then: • an updated Terms of Reference will be published on the ICB website				
Appendices	**Appendix A**	Committee Terms of Reference v1:1			
	Appendix B	NHSE Letter of VSM Pay Award 2022/23			

Report of the Remuneration Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
Remuneration Committee (Statutory Committee)	The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary the committee is required to: • confirm the ICB pay policy including adoption of any national or local pay frameworks for all employees including senior managers/directors (including board members) and non-executive directors. The Committee will: • adhere to all relevant laws, regulations and company policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors whilst remaining cost effective • advise upon and oversee contractual arrangements Directors, including but not limited to termination payments. The Committee's duties are as follows: For the Chief Executive, Directors and other Very Senior Managers: • determine all aspects of remuneration including but not limited to salary, • determine arrangements for termination of employment and other contractual terms and non-contractual terms. For all staff: • determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change). • oversee contractual arrangements • determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.	Tony Foy, ICB Non-Executive Member

Committee	Principal role of the committee	Chair
	For Non-Executive Directors (NEDs): • determine the ICB remuneration policy (including the adoption of pay frameworks) • oversee contractual arrangements. Additional functions that the ICB has chosen to include in the scope of the committee include: • functions in relation to nomination and appointment of (some or all) Board members through convening an ICB Appointments Panel • functions in relation to performance review/ oversight for directors/senior managers • succession planning for the Board • assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and proper person regulation (FPPR) • board development which maybe progressed through a discreet working group.	

2. Meetings held and summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

Decision /Action Log Ref No.	Meeting Date	Issues considered
	28.09.22	**Approach to reducing ICB running costs:** The Committee considered a report outlining the work undertaken to develop an approach to reducing the ICB running costs. The Committee was asked to note the work programme for determining an appropriate staffing structure for the ICB and the steps being taken to ensure that any new structure is appropriately costed and savings against the running costs of the 9 predecessor CCG organisations are made. The Committee were also updated on the NHSE plan to transfer some of their existing functions and responsibilities over to the ICB. The paper outlined the ambition to reduce the ICB management cost envelope by 20% for the ICS, however that this was to be achieved this year.

Decision /Action Log Ref No.	Meeting Date	Issues considered
		The Executive Director of Finance has been tasked to undertake the production of a paper on this to be brought to Board, and which will outline how any savings would be invested into public services.

3. Meetings held and summary of "issues considered and approved/decided under delegation" (not requiring escalation or ICB Board consideration)

The following items were considered and decisions undertaken by the Committee under its delegation from the ICB Board.

Decision /Action Log Ref No.	Meeting Date	Issues considered
REM-DEC-22-09	28.09.22	**Update on Partner Member Pay Framework / Remuneration** The Committee considered a report outlining the proposed remuneration framework for ICB Board Partner members who are entitled to receive a payment. The paper confirmed that the proposed remuneration had been calculated in line with the rates paid to NEDs and for GPs. The Committee approved the recommendations within the paper but recognised further work still need to be completed.
REM-DEC-22-10	28.09.22	**National pay award to VSM staff update** The Committee received a report on and the National Guidance (Appendix A) that had been received regarding a pay award for Very Senior Managers. The national guidance outlined that a 3% pay award should be awarded to all cohorts and that a 0.5% was discretionary for particular staff, however this did not apply to any ICB cases. The Committee agreed to adopt the recommendation within the guidance to award the 3% pay award for the 2022/23 annual pay increase.

4. Issues for escalation to the ICB Board

The following items were considered by the Committee. The committee considered that they should be drawn to the attention of the ICB Board for its consideration:

Decision /Action Log Ref No.	Meeting Date	Issue for escalation
-	28.09.22 & 13.10.22	None

5. Committee recommendations for ICB Board approval

The following items were considered by the Committee. The Committee made particular recommendations to the ICB Board for approval:

Decision / Action Log Ref No.	Meeting Date	Recommendation from the Committee
REM-AC-22-04	28.09.22 & 13.10.22	**Terms of Reference** The Committee considered its Terms of Reference Appendix B) and made a number of minor proposed amendments to recommend for consideration for approval by the Board.

6. Recommendations

6.1 **The ICB Board is asked to:**

- **note** the contents of the report
- **approve** the recommendation to agree the proposed amendments to the Terms of Reference of the ICB Remuneration Committee (Appendix A).

7. Next Steps

7.1 **The following will happen:**

- the ICB Associate Director of Corporate Affairs and Governance will progress (subject to approval) the publication of the updated Committee Terms of Reference on the ICB website.

NHS Cheshire and Merseyside Integrated Care Board Meeting

27 October 2022

Report of the Remuneration Committee Chair

Appendices

- **Appendix A:** Committee Terms of Reference
- **Appendix B:** NHSE Letter on VSM Pay Award 2022/23

NHS
Cheshire and Merseyside

Cheshire & Merseyside ICB

Remuneration Committee

Terms of Reference

Document revision history

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

Review due:
1 July 2023

V1:2 approved by the C&M ICB Board (*October 2022*)

Remuneration Committee

Terms of Reference

Introduction

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

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

1. Purpose

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

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

The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary:

- confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) and non-executive directors.

The Board has also delegated the following functions to the Committee:

- salary, including any performance-related pay or bonus
- provisions for other benefits, including for example pensions and cars and allowances.

The Committee will:

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

2. Responsibilities / duties

The Committee's duties are as follows:

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

- determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, allowances, pensions and cars
- determine arrangements for termination of employment and other contractual terms and non-contractual terms.

For all staff:

- determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change).
- oversee contractual arrangements
- determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

For Non-Executive Directors (NEDs):

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

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

- functions in relation to nomination and appointment of (some or all) Board members through convening an ICB Appointments Panel
- functions in relation to performance review/ oversight for directors/senior managers
- succession planning for the Board
- assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and proper person regulation (FPPR)
- board development which maybe progressed through a discreet working group.

3. Authority

The Remuneration Committee is authorised by the Board to:

- investigate any activity within its terms of reference
- seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference
- obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice
- create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and SoRD but may /not delegate any decisions to such groups.
- commission, review and authorise policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by the ICB Board.

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

4. Membership & Attendance

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

The Board will appoint no fewer than three members of the Committee, of which at least two are NEDs of the Board. Other members of the Committee need not be members of the Board, but they may be.

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

The Committee Membership will be composed of:
- Chair, drawn from one of the ICB NEDs
- all NED members of the ICB may be members of the committee recognising that there may be times when the ICB audit chair needs to abstain from taking part in the meeting.

Up to three other non-executive members drawn from Partner organisations within the C&M system, ideally with experience of remuneration committees and / or remuneration decisions for members of Board, may be called to sit on the Committee in an advisory role and vote on decisions that directly impact on the ICB NEDS, including decisions relating to the remuneration of ICB NEDs.

The ICB Chair will also receive a standing invitation to attend and will sit as a member when there is a need to maintain quoracy or when a decision involving ICB NED members is to be made.

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

Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:
- the ICB's most senior HR Advisor or their nominated deputy
- Director of Finance or their nominated deputy
- Chief Executive or their nominated deputy
- Associate Director of Corporate Affairs and Governance.

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

<u>Management of Conflicts of Interest</u>
No individual should be present during any discussion relating to:
- any aspect of their own pay
- any aspect of the pay of others when it has an impact on them.

5. Meetings

5.1 Leadership

Committee members may appoint a Vice Chair from amongst the standing members.

In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting recognising that this may not be the ICB Chair or Audit Chair.

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

5.2 Quorum

For a meeting or part of a meeting to be quorate a minimum of two of the ICB NED members[1] is required, with one to act as Chair.

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

Members drawn from the ICB Board must always be in the majority as compared to any members appointed to the Committee from external partners.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

5.3 Decision-making and voting

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

Decisions will be taken in according with the Standing Orders of the ICB. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

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

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

5.4 Frequency and meeting arrangements

The Committee will meet in private.

[1] Other than where specified in the constitution to assess NED remuneration where two committee members will also represent the quorum.

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

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

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

5.5 Administrative Support

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

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

5.6 Accountability and Reporting Arrangements

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

A summary of key issues discussed and concluded shall be produced and formally submitted to the Board. Reporting will be appropriately sensitive to personal circumstances and contain no personally sensitive or personally identifiable information.

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

6. Behaviours and Conduct

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

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

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

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

7. Review

The Committee will review its effectiveness at least annually

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

To:

- Provider Trust:
  - Chairs
  - Chief executives
  - HR directors
- ICB
  - Chairs
  - Chief executives
  - HR directors
- Regional
  - Directors
  - Directors of workforce and OD

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 September 2022

Dear colleagues

2022/23 Annual pay increase recommendation for very senior managers (VSMs)

The role of leaders and senior managers has been and continues to be critical to the ability of the NHS to meet the needs of the people we are here to serve.

I am writing to advise you of the recommendation for the 2022/23 annual pay increase for VSMs.

As you will be aware, each year the relevant pay review bodies make recommendations to government on the pay of health service-related public sector staff, including increases to reflect the cost of living. VSM and executive senior manager (ESM) staff groups have for the last two years come under the remit of the Senior Salaries Review Body (SSRB).

The SSRB was asked this year to make recommendations for VSMs and ESMs working in provider trusts, integrated care boards (ICBs) and arm's length bodies, and government has accepted these in full. The 2022/23 VSM pay award will be funded in line with Julian Kelly's letter of 20 July 2022.

The details are:

- An across-the-board increase of 3.0% for all VSMs (and ESMs) is to be applied and backdated to 1 April 2022.

- A further 0.5% at the discretion of the Remuneration Committee to be applied to VSMs on salaries close to the AfC band 9 upper spine point to ameliorate the erosion of differentials (between current Agenda for Change (AfC) and VSM/ESM pay frameworks). This is aimed at facilitating the introduction of the new VSM pay framework over the course of the coming year.

As in previous years, medical directors on the consultant contract will receive the agreed award of their consultant pay, as recommended by the Review Body on Doctors' and Dentists' Remuneration (DDRB), with the 3% (SSRB) uplift applied only to their management allowance.

Local remuneration committees have the discretion to apply the additional 0.5% as 0.5% of an individual's base pay to help address differentials, and in particular to ameliorate the erosion of the differential with the top AfC band (Band 9) where necessary.

While the award is backdated to 1 April 2022, it is not recommended for those subject to formal performance management/disciplinary procedures.

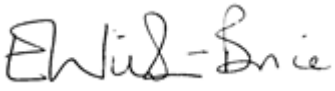
I also want to remind you that ministerial comment (for NHS foundation trusts or ICBs) or approval (for NHS trusts) will continue to be required if the £150,000 consolidated threshold (for NHS foundation trusts and NHS trusts) or £170,000 or operational maximum, whichever is lower (for ICB executive directors) will be exceeded. Any employer who wants to pay above the recommended pay award, eg where the uplift above 3% would take an individual's pay above the relevant ministerial scrutiny thresholds or where the individual is already being paid above those thresholds, would therefore need to submit a pay case for approval or comment in the usual way.

As mentioned above, a new VSM pay framework is currently in development and the necessary approvals will be sought as soon as possible.

Please direct any individual questions on VSM pay to england.vsmcases@nhs.net.

This has been another extraordinary year and I'd like to end this letter by expressing my gratitude for and recognition of your individual and collective contributions.

Yours sincerely,



Professor Em Wilkinson-Brice
National Director for People
NHS England

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

13 October 2022

Report of the Quality & Performance Committee Chair

Agenda Item No	**ICB/10/22/16**
Report author & contact details	Kerry Lloyd, Deputy Director of Nursing & Care kerry.lloyd@cheshireandmerseyside.nhs.uk
Report approved by (sponsoring Director/ Chair)	Tony Foy, Chair
Responsible Officer to take actions forward	Kerry Lloyd, Deputy Director of Nursing & Care

Cheshire and Merseyside ICB Board Meeting

NHS Cheshire and Merseyside

Report of the Quality & Performance Committee Chair

Executive Summary	The purpose of this report is to provide assurance to the C&M Integrated Care Board in regard to key issues, considerations, approvals and matters of escalation considered by the C&M ICB Quality & Performance Committee in securing continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centered, well-led, sustainable and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care, coupled with a focus on performance.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X	X	X		
Recommendation	**The Board is asked to:** 1. Section 2 - note the content 2. Section 3 - note the content and the issues considered by the Committee and actions taken. 3. Section 4 - Consider the matters escalated to the ICB Board regarding: ▪ Annual Health Checks for People with Learning Disabilities.				
Key issues	None to note				
Key risks	None to escalate				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	X	X	X	X	
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
	X	X	X	X	
Management of Conflicts of Interest	No conflicts of interest declared at the Committee.				
Next Steps	Noted in the body of report.				
Appendices	None				

Report of the Quality & Performance Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
Quality & Performance Committee	The Quality and Performance Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centred, well-led, sustainable and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care, coupled with a focus on performance. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care. The committee will focus on quality performance data and information and consider the levels of assurance that the ICB can take from performance oversight arrangements within the ICS and actions to address any performance issues. In particular, the Committee will provide assurance to the ICB on the delivery of the following statutory duties: • Duties in relation children including safeguarding, promoting welfare, SEND (including the Children Acts 1989 and 2004, and the Children and Families Act 2014); and • Adult safeguarding and carers (the Care Act 2014).	Tony Foy

2. Meetings held and summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

<table>
<tr><th>Decision Log Ref No.</th><th>Meeting Date</th><th>Issues considered</th></tr>
<tr><td>QPC/10/22/04</td><td>13/10/2022</td><td>ICB Q&P Committee Key Issues Report
The Chairs key issues report was presented to Committee to ensure 2-way communication between the Committee and the Board is transparent and to feedback on any matters that were considered at the ICB Board meeting.
Two matters escalated for consideration by the Board:
Health Checks for people with learning disabilities performance
Board satisfied that oversight by the Committee will be undertaken at next meeting regarding action plans for improvement on current performance and trajectories.
No One's Listening Enquiry
Consideration by CMAST as to implementation of recommendations to be considered. Acknowledged as a priority for the ICB.</td></tr>
<tr><td>QPC/10/22/07</td><td>13/10/2022</td><td>Cancer Survey and Focused Local Views
Presentation received from Cancer Alliance.
The National Cancer Patient Experience Survey 2021 is the 11th iteration of the survey first undertaken
in 2010. It has been designed to monitor progress on cancer care; to provide information to drive local
quality improvements; to assist commissioners and providers of cancer care; and to inform the work of
the various charities and stakeholder groups supporting cancer patients.
The 2021 survey involved 134 NHS Trusts.<table><tr><td></td><td>Sample</td><td>Completed</td><td>Response Rate</td></tr><tr><td>C&M</td><td>2,973</td><td>1,610</td><td>54%</td></tr><tr><td>National</td><td>107,412</td><td>59,352</td><td>55%</td></tr></table></td></tr>
</table>

Decision Log Ref No.	Meeting Date	Issues considered
		• C&M has no scores below expected range across 50 questions about patient experience over the whole pathway. C&M Cancer Alliance undertook a roadshow May – July 2022 and travelled across 10 locations in C&M in partnership with Healthwatch's and Macmillan Cancer Support. The purpose was to listen to the people of C&M, their cancer experiences and understand how people are feeling about cancer services in their local areas. • Challenges that were identified across the region included ○ communication issues, both within and between primary and secondary care; and, ○ a need for greater access to mental health support for both the patients and their loved ones. ○ It was also found some people were currently experiencing potential symptoms of cancer, but attributed this to long Covid. • A secondary aim of the Roadshow was to recruit patient representatives from diverse backgrounds; and, a total of 29 people volunteered to share their patient story/become a patient representative. The CMCA Facebook page also gained an additional 56 new page likes/followers. Findings from the roadshow will be shared with stakeholders and outcomes will continue to be monitored during 2023/24.
QPC/10/22/08	13/10/2022	**Quality & Performance Dashboard** • Director of Performance, Medical Director and Director of Nursing and Care have met to discuss the format of the Committee dashboard and the accompanying narrative required. • Committee agreed that much work has been undertaken to date and progress was visible. • Following further work in October 2022 a revised dashboard will be presented in November 2022. • Performance dashboard to remain on action log and workplan until members satisfied. In depth discussion by committee members regarding performance in: • Urgent and Emergency Care • Cancer waiting times

Decision Log Ref No.	Meeting Date	Issues considered
		○ Diagnostics sited as most challenging • Positive progress regarding 104 week waits noted, with a renewed focus to reduce 78 week trajectory noted.
QPC/10/22/08	13/10/2022	**Place Quality & Performance Group aggregated Key Issues Report** • A focus on commissioned and provided services in the Cheshire geographical area was undertaken this month. • Associate Directors of Quality from Cheshire East, Cheshire West, Warrington, Halton and Wirral were invited to enable a confirm and challenge discussion with information provided. • Committee felt assured that systems and processes were in place for oversight and scrutiny of the quality, safety and experience of care commissioned and delivered, including a robust escalation process. • November Committee will focus on Merseyside geographical area to all for a deep dive.
QPC/10/22/12	13/10/2022	**C&M All Age Continuing Healthcare System Oversight Group**. • The Committee heard that to date the C&M HCP in preparation of the transition to the ICB, drew together Heads of CHC service's and LA representatives across Cheshire and Merseyside to define and agree, a future vision for all-age continuing care in C&M. • A report describing the readiness for transition and the future operating model framework was presented by Interim Director of Nursing and Care to the executive leadership team of the HCP in March 2022. The Executive team also supported the establishment of a transformation programme with resource for a Programme Director. • Cheshire and Merseyside Places have continued to deliver the AACC services in the pretransition configuration and further discussion and agreement has taken place to refine the aims and objectives of the programme. • A workforce proposal is in development with the anticipation that the process will be concluded • in October 2022.

Decision Log Ref No.	Meeting Date	Issues considered
		• Further update reports will be provided to Quality and performance committee as a full and comprehensive review of AACHC is underway • The committee recommended that performance data relating to AACHC be added to dashboard for onward review.

3. Meetings held and summary of "issues considered and approved/decided under delegation" (not requiring escalation or ICB Board consideration)

The following items were considered, and decisions undertaken by the Committee under its delegation from the ICB Board.

Decision Log Ref No.	Meeting Date	Issues considered
QPC/10/22/10	13/10/2022	**One to One Midwifery Investigation** • Niche Health and Social Care Consulting were asked to review the circumstances which led to the cessation of community maternity services provided by One to One Midwives. The work included consideration of the commissioning and contracting processes, governance and oversight, and financial viability as well as the chronology of events which led to the cessation of the service. • The work did not include a clinical review of cases; however, they did review quality and safety risks, clinical governance, broad clinical outcomes and patient experience. In all, they were contacted by 395 families who wanted to share their experiences with them, most, but not all families, were positive in their views about the service. • There were: ○ **7 Key recommendations** for Maternity Services Commissioning made. ○ Alongside this there are **key learning points** regarding quality & safety, culture and relationships, system oversight, financial viability, tariff arrangements, contract and

Decision Log Ref No.	Meeting Date	Issues considered
		performance management, service specifications, procurement and contracting, national policy and due diligence for the system to respond to. ○ **4 learning quadrants**: ▪ National and System learning ▪ Commissioners ▪ NHS Providers ▪ Independent Sector Providers NHS England are holding an Action Planning meeting on 28th October 2022, which will be followed by an assurance framework. This meeting is being attended by Deputy Director of Nursing & Care. Progress on implementation of the actions is scheduled on the Committee workplan.
QPC/10/22/13	13/10/2022	**National Screening & Immunisation Programme (Q1 & Q2)** Assurance overview received of Section 7a Services which are NHS public health functions agreements set out the arrangements under which the Secretary of State delegates responsibility to NHS England for certain public health services (known as Section 7A services). The services currently commissioned in this way are: • national immunisation programmes • national cancer and non-cancer screening programmes • Child Health Information Services (CHIS) • public health services for adults and children in secure and detained settings in England • sexual assault services (Sexual Assault Referral Centres) Agreement in line with workplan to receive a report quarterly at committee.
QPC/10/22/14	13/10/2022	**C&M Safeguarding Children, Children in Care and Adults** Endorse the following policies which were approved at the ICB System Safeguarding Oversight Group on

Decision Log Ref No.	Meeting Date	Issues considered
		28th September 2022 in line with its Terms of Reference • Managing Allegations Made Against Staff in Respect of Children, Young People and Adults at Risk Policy • Domestic Abuse Support for Employees Policy • Mental Capacity Act (2005) Policy
QPC/10/22/15	13/10/2022	**Escalation items for consideration** to: • C&M SQG ○ Maternity Services ○ One to One Midwifery Investigation findings • C&M ICB ○ Annual Health Checks for People with Learning Disabilities. • Risk Register

4. Issues for escalation to the ICB Board

The following items were considered by the Committee. The committee considered that they should be drawn to the attention of the ICB Board for its consideration:

Decision Log Ref No.	Meeting Date	Issue for escalation
QPC/10/22/11	13/10/2022	**C&M Transforming Care Programme – Learning Disability Annual Health Checks (AHC) Report** • Following presentation of an assurance paper regarding the Transforming Care for People with Learning Disabilities programme in September 2022. A request to return to committee to enable a deep dive and focused discussion regarding the Annual Health Checks of People with Learning Disabilities was requested. **Performance:** Target: 75% C&M 2021/22: 71.7% C&M 2022/23 Q2: 2% - 10.8% by Place. Early uptake data indicates that the delivery profile remains same 2021/22, therefore as in previous years

		it is anticipated that delivery will peak in Quarter 3 and Quarter 4, which presents greater risks. **Challenges:** • LD Health Checks are an NHS Directed Enhanced Service and not mandatory • As in previous years GP practices tend to undertake AHC's in January and February after flu season and winter period. • Reduced restrictions this year mean more face-to-face consultations, however patients are still reluctant to come in for their appointments. • High rate of DNA reported despite suitable appointment arranged. **Recovery Actions:** • Performance is monitored locally whereby each GP practice performance data in this area is available – this enables local commissioners to see which Practices are doing well and those who are having difficulties or require support. • To level up compliance in each quarter it has been suggested that the AHCs are completed when it is the individual's birthday, which would minimise the back log in Quarter 4. • GP Practices who are underdelivering against target are being encouraged to begin with patients they did not see last year (outstanding AHCs continue to be targeted). • A risk assessment tool is being encouraged to identify those patients who need face to face AHCs. • Most practices make at least 3 contacts with the patient to encourage them to come in. Contact is made in a variety of ways between phone, text messaging and easy read letters but patients can be challenging to reach or can fail to attend an agreed appointment. • Flexible solutions have been sought in terms of location and provision of dedicated space for LD/Autism patients to better enable reasonable adjustments. **Good Practice** • The Pilot Scheme in **South Sefton** which is being delivered by South Sefton GP Federation is now up and running (August 2022). Two Registered Nurses, both working 2 days a

		week have been recruited. They are calling the patients personally and offering them a Health check and explaining at length what is involved. They have a choice of a home visit or a clinic visit, and if they do not wish either of those a virtual video consultation. **Wirral place** is an Exemplar site; working to increase uptake and awareness of people aged 14 - 17 years old (not exclusively). The aim is to increase awareness and uptake of annual health checks and quality audit of health actions primarily in this age group. **Committee agreed that comprehensive assurance was received with robust action planning. Committee will receive a further update in January 2023 to review progress on performance.**

5. Committee recommendations for ICB Board approval

The following items were considered by the Committee. The Committee made particular recommendations to the ICB Board for approval:

Decision Log Ref No.	Meeting Date	Recommendation from the Committee
-	-	-

6. Recommendations

6.1 **The ICB Board is asked to:**

1. Section 2 note the content
2. Section 3 note the content and the issues considered by the Committee and actions taken
3. Section 4 Consider the matters escalated to the ICB Board regarding:
   - Annual Health Checks for People with Learning Disabilities.

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

27 October 2022

Report of the Transformation Committee Chair

Agenda Item No	**ICB/10/22/17**
Report author & contact details	Neil Evans; Associate Director of Strategy and Collaboration neilevans@nhs.net
Report approved by (sponsoring Director/ Chair)	Clare Watson; Assistant Chief Executive
Responsible Officer to take actions forward	Neil Evans; Associate Director of Strategy and Collaboration neilevans@nhs.net

Cheshire and Merseyside ICB Board Meeting

Report of the Transformation Committee Chair

Executive Summary	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 development and delivery of our strategic plans. The meeting considered: • Committee Terms of Reference • the draft Integrated Care System Digital and Data Strategy • a programme reviewing the current change activity occurring across the Cheshire and Merseyside system in order to inform future priorities and delivery approaches • the NHS England Substantial Service Change Assurance Process • development of the Integrated Care Partnership Strategy. The Transformation Committee has asked for further reports to be presented to their next committee in relation to: • receiving the final Data and Digital Strategy for the Integrated Care System • review of current change activity and recommendations on future plans • development of a prioritisation process in relation to substantial change programmes • work with system stakeholders to develop the ICP Strategy by the nationally set deadline of December 2022 • the Transformation Committee Terms of Reference – which are being presented to this (October) ICB Board Meeting for approval.

Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
		x	x		

Recommendation	**The Board is asked to:**
	• **note** the areas discussed at the first meeting of the committee in relation to:
	  • the draft Integrated Care System Digital and Data Strategy
	  • praogramme reviewing the current change activity occurring across the Cheshire and Merseyside system in order to inform future priorities and delivery approaches
	  • the NHS England Substantial Service Change Assurance Process
	  • development of the Integrated Care Partnership Strategy.
	
	• **approve** the revised terms of reference attached to this paper. The revisions relate to ensuring the full range of statutory duties the committee will assure the Board was fully included, refining the committee membership and some wording revisions.

NHS Cheshire and Merseyside Integrated Care Board Meeting

Key issues	The Department of Health and Social Care has issued guidance requiring publication of an ICP Strategy by December 2022. The approach to be taken to meet this stretching deadline is referenced in Section Two.			
Key risks	Resource availability(human and financial) may be insufficient to deliver the programme priorities across our system. In Section Two a review exercise of existing change programme content and delivery approaches is taking place; which will inform our future programme content and delivery approach.			
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**
		x		
	Legal	**Health Inequalities**	**EDI**	**Sustainability**
	x	x	x	x
Management of Conflicts of Interest	Not applicable			
Next Steps	Subject to the approval of the Board, the updated Committee Terms of Reference will be published on the ICB website.			
Appendices	**Appendix A**	Committee Terms of Reference		

Report of the Transformation Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
Transformation	Provide a leadership forum, across the system, to consider the development and implementation of the ICP strategy and policy and plans of the ICB securing continuous improvement of the quality of services Retain a focus on health inequalities and improved outcomes and ensure that the delivery of the ICP / ICB's strategic and operational plans are achieved within financial allocations.	Clare Watson *(pending appointment of Clinical Non-Executive Director)*

2. Meetings held and summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

Decision Log Ref No.	Meeting Date	Issues considered
-	22.09.22	A presentation describing the draft Integrated Care System Digital and Data Strategy was presented and the Committee made some recommendations in relation to content and supported the wider socialisation of the strategy in advance of considering the final strategy at the November meeting, in advance of being presented to the ICB Board for approval.
-	22.09.22	A programme reviewing the current change activity occurring across Places, Corporate Programmes and Provider Collaboratives, within the Cheshire and Merseyside system, in order to inform future priorities and maximise the efficiency and effectiveness of delivery approaches was considered. An update on the approach being taken to this work will be presented to the November Committee with a final report presented in January.
-	22.09.22	The NHS England Substantial Service Change Assurance Process was outlined noting that Programmes of work enter this process where public consultation is identified by the Local Authority Health Overview and Scrutiny Committee. Plans to develop a prioritisation process for substantial change, with peer ICBs was agreed as an action.

Decision Log Ref No.	Meeting Date	Issues considered
	22.09.22	The process for the development of the Integrated Care Partnership Strategy was outlined. This report confirmed that stakeholders, including through an ICB Board development session in October 2022 would be engaged in developing the strategy. It was noted that the Department of Health and Social Care has set a deadline of December 2022 for the publication of an ICP Strategy, which may be interim in status with revised national guidance planned for the summer of 2023. It was noted that the ICP Board was not yet operational and that engagement activity would be undertaken in the context of both this and the limited time available; with existing strategies and policies used as the core of the strategy.

3. Meetings held and summary of "issues considered and approved/decided under delegation" (not requiring escalation or ICB Board consideration)

The following items were considered and decisions undertaken by the Committee under its delegation from the ICB Board.

Decision Log Ref No.	Meeting Date	Issues considered
		Not applicable

4. Issues for escalation to the ICB Board

The following items were considered by the Committee. The committee considered that they should be drawn to the attention of the ICB Board for its consideration:

Decision Log Ref No.	Meeting Date	Issue for escalation
		Not applicable

5. Committee recommendations for ICB Board approval

The following items were considered by the Committee. The Committee made particular recommendations to the ICB Board for approval:

Decision Log Ref No.	Meeting Date	Recommendation from the Committee
-	22.09.22	Revised Terms of Reference were reviewed by the Committee and require ICB Board approval.

6. Recommendations

6.1 **The ICB Board is asked to:**

- **Note** the areas discussed at the first meeting of the committee in relation to
  - the draft Integrated Care System Digital and Data Strategy
  - a programme reviewing the current change activity occurring across the Cheshire and Merseyside system in order to inform future priorities and delivery approaches
  - the NHS England Substantial Service Change Assurance Process
  - development of the Integrated Care Partnership Strategy.

- **Approve** the revised terms of reference attached to this paper. The revisions relate to ensuring the full range of statutory duties the committee will assure the Board was fully included, refining the committee membership and some wording revisions.

7. Next Steps

7.1 Subject to the approval of the ICB Board, the updated Committee Terms of Reference will be published on the ICB website.

7.2 The Transformation Committee has asked for further reports to be presented to their next committee in relation to:

- receiving the final Data and Digital Strategy for the Integrated Care System
- review of current change activity and recommendations on future plans
- development of a prioritisation process in relation to substantial change programmes.

7.2 Work with system stakeholders to develop the ICP Strategy by the nationally set deadline of December 2022.

7.3 The Transformation Committee Terms of Reference are being presented to this (October) ICB Board Meeting for approval.

NHS Cheshire and Merseyside Integrated Care Board Meeting

27 October 2022

Report of the Transformation Committee Chair

Appendices

NHS
Cheshire and Merseyside

C&M ICB Transformation Committee

Terms of Reference

Version 2.1

Document revision history

Date	Version	Revision	Comment	Author / Editor
01 July 2022	1.0	Initial ToRs		Ben Vinter
15 September 2022	2.0	Initial proposed revisions		Natalie Robinson
19 October 2022	2.1	Revisions following agreement at the September Committee Meeting		Neil Evans

Review due:
Octo~~Septem~~ber 2023

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1. Introduction

NHS C&M has been established to

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

The Transformation Committee (the "Committee") has been established in accordance with the NHS C&M constitution.

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

The Committee is an executive led forum, with non-executive involvement and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of NHS C&M.

2. Role and Purpose

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

- Provide a Board, Place and Provider Collaborative leadership forum to consider the development and implementation of the ~~commissioning~~ ICP strategy and policy and plans of the ICB securing continuous improvement of the quality of services
- Connect with and ensure alignment of system programmes as may be developed by any of the system's constituent parts: progammes reporting to the ICB/ICP or provider collaboratives as appropriate~~P (digital, population health~~), ~~the collaborative, and place or the ICB boards.~~
- Connect with, refer issues for clinical consideration to and develop responses to actions or issues identified by the ICB's Clinical and Care Professional Advisory Council or other appropriate fora as established.
- Retain a focus on reducing health inequalities and improved outcomes and ensure that the delivery of the ICP / ICB's strategic and operational plans are achieved within financial allocations
- Consider the effects of decisions on people's health and wellbeing, quality of services and efficiency and sustainability
- Have delegated authority to make decisions within the limits as set out in the ICB's Schemes of Reservation and Delegation.

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

- *Duty to commission certain specified health services*
- *Duty as to reducing inequalities*
- *Duty as to patient choice*
- *Duty to exercise functions effectively, ~~efficiently~~efficiently, and economically*
- *Duty to obtain appropriate advice*
- *Duty to promote innovation*

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

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

a) Overseeing the development and review of the ICB ~~commissioning~~ plans in response to the ICP's developed strategy, ensuing they take account of the population need.

b) ~~Developing~~ Overseeing the development the ICB's operational ~~commissioning P~~and transformational plans ~~and annual commissioning intentions on the advice of the Quality and Performance Committee~~ (making recommendations to the ICB on their approval), supporting alignment of Place priorities at an aggregate level and engaging with partners ~~including collaboratives of delivery potential.~~across the wider system (including VCSE and the social care sector).

c) Ensuring our plans and clinical commissioning policies follow the principle of proportionate universalism with the ambition to reduce health inequalities and reduce avoidable mortality.

~~b)~~

~~c)~~d) Overseeing the development and delivery of work programmes that support the ICB's strategy and operational plans, including oversight of areas developing joint commissioning with partner organisations (and making recommendations to the ICB on their approval as required).

~~d)~~e) Receiving reports on ~~contractual~~ transformation delivery, ~~performance and~~ including financial management and escalating issues to the ICB as appropriate.

~~e)~~f) Receiving assurance on the ICBs' provider collaboratives' development processes.

~~f)~~g) Linking with the ICB's Specialised Commissioning arrangements and Primary Care Committees to ensure the system wide, ~~population based~~population-based approach is implemented to delegated NHSE functions

~~g)~~h) Overseeing the coordination and integration of services to support the delivery of effective, high quality, accessible services, including via an aggregated view ICB Better Care Fund implementation.

~~h)~~i) Ensuring that ~~commissioning~~ transformation activities promote the health and wellbeing of communities as well as addressing health inequalities, prioritising investment / disinvestment and ~~commissioning activities to~~ ensure cost effective care is delivered; developing an evidence-based commissioning/decommissioning framework.

~~i)~~a) ~~Ensuring clinical commissioning policies follow the principle of proportionate universalism with the ambition to reduce health inequalities and reduce avoidable mortality.~~

j) Ensuring that ~~commissioning~~ plans and ~~decisions are~~decisions are underpinned and informed by communications and engagement with key stakeholders, including the local population as appropriate.

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k) Taking account of collaborative commissioning activities, including those of clinical networks, to ascertain if they will have wider contracting / financial implications for the ICB (for referral to the Finance Committee / ICB if appropriate).

~~l)~~ Overseeing and providing senior Board level sponsorship to programmes integral the social value contribution of the ICB.~~:~~

~~m) VSFSE~~

~~n) Anchor institutions~~

~~o) Sustainability~~

~~p)~~l) ~~Partnership initiatives~~

m) Making decisions in line with its remit in accordance with the financial delegation of the Executive Directors and directors present, in line with the NHS C&M Scheme of Reservation & Delegation

~~q)~~n) Making recommendations on investment and significant commissioning decisions to the ICB.

3. Authority

The Committee is authorised by the ICB to:

- Request further investigation or assurance on any area within its remit
- Bring matters to the attention of other committees to investigate or seek assurance where they fall within the remit of that committee
- Make recommendations to the ICB or ICP
- Escalate issues to the ICB or ICP
- Produce an annual work plan to discharge its responsibilities
- Approve the terms of reference of any sub-groups to the committee
- Delegate responsibility for specific aspects of its duties to sub-groups. The terms of reference of any subgroups shall be approved by the Committee.

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

4. Membership & Attendance

4.1 Members

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

Membership of the Committee may be drawn from the ICB: Board membership; ICB executive; supporting officers; wider partners in the wider health and social care system; other individuals / representatives as deemed appropriate.

The Committee members shall be:

- Non-Executive Director
- One of the ~~Primary Medical Services~~ ICB Partner Member(s) - Providers of Primary Medical Services
- Chair of the C&M Primary Care Leadership Group
- Director of Nursing
- Medical Director
- Executive Director of Finance or designate
- Assistant Chief Executive (Chair of the Committee)
- Two Place Directors
  - one of whom will be the lead for the ICB on specialised commissioning
  - one of whom will be an integrated ICB / LA appointment
- Local authority representative from public health or commissioning
- Local authority representative from DASS or DCS[1]
- Consultant in population health
- A representative from each of the C&M Provider Collaboratives

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

The ICB Chief Executive may attend as determined necessary.

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

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

4.2 Attendees

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

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

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

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

5. Meetings

5.1 Leadership

The Committee shall be chaired by the Clinical Non-Executive Member of the ICB Board ~~an executive~~. They will appoint a Deputy Chair.

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

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

5.2 Quorum

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

- At least five Committee members in total;
- At least one NED or system Partner*
- At least one Clinical Member*
- At least two ICB Directors (or their nominated deputies).

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

5.3 Decision-making and voting

Decisions should be taken in accordance with the financial delegation of the Executive Directors and directors present, in line with the NHS C&M Scheme of Reservation & Delegation.

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

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

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

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

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

5.4 Frequency

The Committee will meet in private.

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

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

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

5.5 Administrative Support

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

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

5.6 Accountability and Reporting Arrangements

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

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

The Committee will submit copies of its minutes and a report to the ICB following each of its meetings. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

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

6. Behaviours and Conduct

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

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

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

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

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

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

Equality diversity and inclusion

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

7. Review

The Committee will review its effectiveness at least annually

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