Thursday 30 March 2023
09:00am-12noon
Boardroom, The Department, Lewis's Building,
2 Renshaw Street, Liverpool, L1 2SA

NHS
Cheshire and Merseyside

Meeting of the Integrated Care Board

Agenda

Chair: Raj Jain

The ICB Board meeting are business meetings which, for transparency, are held in public. They are not 'public meetings' for consulting with the public, which means that those people who attend the meeting cannot take part in the meetings proceedings. There will be opportunity for members of the public to ask questions to the Board at the end of the meeting.

The ICB Board meeting is live streamed and recorded.

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
09:00am	**Preliminary Business**			
ICB/03/30/01	Welcome, Introductions and Apologies	Chair	Verbal	-
ICB/03/30/02	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). Register of Interest available at: https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/managing-conflicts-of-interest/*	Chair	Verbal	-
ICB/03/30/03	Minutes of the previous meeting: • 23 February 2023	Chair	Paper Approval	Page 4
ICB/03/30/04	Board Action Log	Chair	Paper For note	Page 19
ICB/03/30/05	Board Decision Log	Chair	Paper For note	Page 24
09:10am	**Standing Items**			
ICB/03/30/06	Chairs Announcements	Chair	Verbal	
ICB/03/30/07	Report of the Chief Executive	GPU	Paper For note	Page 28
ICB/03/30/08	Resident / Staff Story	-	Presentation For note	
09:30am	**ICB Key Update Reports**			
ICB/03/30/09	Executive Director of Nursing & Care Update Report	CDO	Paper For noting	Page 44
ICB/03/30/10 **09:40am**	Cheshire & Merseyside System Month 11 Finance Report	CWI	Paper For noting	Page 50
ICB/03/30/11 **09:50am**	Cheshire & Merseyside ICB Quality and Performance Update Report	ATO	Paper For noting	Page 67
10:00am	**ICB Business Items**			
ICB/03/30/12	Northwest Specialised Commissioning Joint Working Agreement	CWA	Paper For approval	Page 117
ICB/03/30/13 **10:15am**	2022-2023 Emergency Preparedness, Resilience and Response Core Standards Assurance Report	ATO	Paper For noting	Page 211

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
Cont…	**ICB Business Items**			
ICB/03/30/14 **10:20am**	Cheshire and Merseyside People Board Update	CSO	Presentation For noting	Page 228
ICB/03/30/15 **10:35am**	NHS Cheshire and Merseyside ICB NHS Staff Survey results 2022-23: Results and Actions	CSA	Paper & Presentation For noting & Endorsement	Page 245 Page 252
ICB/03/30/16 **10.50am**	Cheshire and Merseyside Cancer Alliance Update	RPJ	Paper For noting	Page 267
11:20am	**Sub-Committee Reports**			
ICB/03/30/17	Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee	TFO	Paper For noting	Page 301
ICB/03/30/18 **11:25am**	Report of the Chair of the Cheshire & Merseyside ICB Audit Committee	NLA	Paper For noting	Page 308
ICB/03/30/19 **11:30am**	Report of the Chair of the Cheshire & Merseyside ICB System Primary Care Committee	EMO	Paper For noting	Page 317
ICB/03/30/20 **11:35am**	Report of the Chair of the Cheshire & Merseyside ICB Finance, Investment and Resources Committee	EMO	Paper For noting	Page 323
ICB/03/30/21 **11:40am**	Report of the Chair of the Cheshire & Merseyside ICB Transformation Committee	CWA	Paper For noting	Page 328
11:45am	**Other Formal Business**			
ICB/02/23/22	Closing remarks, review of the meeting and communications from it	Chair	Verbal	-
12noon	**CLOSE OF MEETING**			

Date and time of next meeting:
27 April 2023 09:00a Boardroom, The Department, Lewis's Building, 2 Renshaw Street, Liverpool, L1 2SA

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

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-Executive Director
- at least one Partner Member; and
- at least one member who has a clinical qualification or background.

Speakers

ATO	Andrew Thomas, Associate Director of Planning, C&M ICB
CDO	Christine Douglas MBE, Director of Nursing and Care, C&M ICB
CSO	Christine Samosa, Chief People Officer, C&M ICB
CWA	Clare Watson, Assistant Chief Executive, C&M ICB
CWI	Claire Wilson, Executive Director of Finance, C&M ICB
EMO	Erica Morriss, Non-Executive Director, C&M ICB
GPU	Graham Urwin, Chief Executive, C&M ICB
NLA	Neil Large, Non-Executive Director, C&M ICB
RPJ	Rowan Pritchard-Jones, Medical Director, C&M ICB
TFO	Tony Foy, Non-Executive Director, C&M ICB

NHS
Cheshire and Merseyside

Integrated Care Board Meeting held in Public

Held at Whiston Town Hall, Old Colliery Road, Whiston, Merseyside, L35 3QX
Thursday 2 March 2023
10.30am to 13.05pm

The Board meeting was recorded and available to watch at:
https://www.youtube.com/live/SNLapM9l9ec?feature=share

UNCONFIRMED Draft Minutes

MEMBERSHIP		
Name	**Initials**	**Role**
Raj Jain	RJA	Chair, Cheshire & Merseyside ICB **(voting member)**
Graham Urwin	GPU	Chief Executive, Cheshire & Merseyside ICB **(voting member)**
Claire Wilson	CWI	Executive Director of Finance, Cheshire & Merseyside ICB **(voting member)**
Christine Douglas MBE	CDO	Executive Director of Nursing and Care, Cheshire & Merseyside ICB **(voting member)**
Tony Foy	TFO	Non-Executive Director, Cheshire & Merseyside ICB **(voting member)**
Neil Large	NLA	Non-Executive Director, Cheshire & Merseyside ICB **(voting member)**
Hilary Garratt CBE	HGA	Non-Executive Director, Cheshire & Merseyside ICB **(voting member)**
Ann Marr OBE	AMA	Partner Member, Chief Executive, St Helens & Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital Trust **(voting member)** (up to item ICB/02/23/13)
Adam Irvine	AIR	Partner Member, Chief Executive Office, Community Pharmacy Cheshire and Wirral (CPCW**) (voting member)**
Dr Naomi Rankin	NRA	Partner Member, Primary Care (GP) Partner Member **(voting member)**
Prof. Steven Broomhead	SBR	Partner Member, Chief Executive, Warrington Borough Council **(voting member)**
Councillor Paul Cummins	PCU	Partner Member, Cabinet Member for Adult Social Care, Sefton Council **(voting member)**
IN ATTENDANCE		
Dr Fiona Lemmens	FLE	Associate Medical Director, Cheshire & Merseyside ICB **(Regular Participant)**
Anthony Middleton	AMI	Director of Performance and Improvement, Cheshire & Merseyside ICB **(Regular Participant)**
Christine Samosa	CSA	Director of People, Cheshire & Merseyside ICB **(Regular Participant)**
Clare Watson	CWA	Assistant Chief Executive, Cheshire & Merseyside ICB **(Regular Participant)**

Matthew Cunningham	MCU	Associate Director of Corporate Affairs & Governance / Company Secretary
Warren Escadale	WES	Chief Executive, Voluntary Sector North West **(Regular Participant)**
Alison Lee	CMA	Place Director – Knowsley
Sarah McNulty	SMN	Director of Public Health, Knowsley
Louise Murtagh	LMU	Corporate Governance Manager, Cheshire & Merseyside ICB (minutes)
Paul Mavers	PMA	Manager, Healthwatch Knowsley
Rachael Jones	RJO	Chief Executive Officer, One Knowsley
Dawn Bowyer	DBO	Cheshire & Merseyside ICB

APOLOGIES NOTED		
Prof. Joe Rafferty CBE	JRA	Partner Member, Chief Executive Office, Mersey Care NHS Trust, **(voting member)**
Prof. Rowan Pritchard-Jones	RPJ	Medical Director, Cheshire & Merseyside ICB **(voting member)**
Prof. Ian Ashworth	IAS	Director of Public Health representative **(Regular Participant)**
Erica Morriss	EMO	Non-Executive Director, Cheshire & Merseyside ICB **(voting member)**

Item	Discussion, Outcomes and Action Points	Action by
10.30am	**Preliminary Business**	
ICB/02/23/01	**Welcome, Introductions and Apologies**	
	RJA welcomed all present at the meeting. Attendees were advised that this was a meeting held in public. Apologies were noted and recorded.	
ICB/02/23/02	**Declarations of Interest**	
	PMA had informed the Chair in advance of his recorded declaration in relation to agenda item ICB/01/23/17. This was not considered a significant conflict that required any other action than noting. There were no other declarations of interest made by Members that would materially or adversely impact on matters requiring discussion and decision on the items being considered at today's Board.	
ICB/02/23/03	**Minutes of the last meeting – 26 January 2023**	
	Members reviewed the minutes of the meeting held on 26 January 2023 and agreed that they were a true reflection of the discussions and decisions made subject to the following additions to minute ICB/01/23/12: • The meeting was adjourned at 12.20pm for 40 minutes to allow members of the public to speak with senior ICB representatives. • PCU expressed concern that the Review had not included local authorities outside of Liverpool in consultation, despite the hospitals involved serving wider populations. There also seemed to be confusion over the difference between the City of Liverpool and the Liverpool City	

Item	Discussion, Outcomes and Action Points	Action by
	Region **The Integrated Care Board approved the minutes of ICB Board meeting of 26 January 2023 subject to the agreed amendments.**	
ICB/02/23/04	**Action Log**	
	The Board acknowledged the completed actions and updates provided in the document. Actions ICB-AC-22-01, ICB-AC-22-02, ICB-AC-22-03, ICB-AC-22-07 and ICB-AC-22-08 were listed on the log as completed and members agreed to close the entries. **The Integrated Care Board noted the Action Log.**	
ICB/02/23/05	**Decision Log**	
	Members reviewed the decision log and confirmed it was an accurate record of substantive decisions made by the Board to date. It was further noted that there were no emergent actions arising from those decisions that were due for review at this meeting. **The Integrated Care Board noted the Decision Log.**	
10.40am	**STANDING ITEMS**	
ICB/02/23/06	**Report of the Chief Executive (Graham Urwin)**	
	GPU presented the Chief Executive Report to the Committee and commented on the following items: **Appointments to the ICB Board** The ICB had successfully appointed Hilary Garratt CBE (Non-Executive Director) and Dr Naomi Rankin (Partner Member) to the Board, and both were formally attending their first Board meeting. With the successful appointment to these two vacancies, all identified roles on the Board, as outlined within our Constitution, had been filled and the Board was asked to formally note the appointments. **Industrial Action** GPU asked that the ICBs appreciation and gratitude to the continued professionalism and commitment of NHS service managers be recorded in the minutes. They had not only maintained services during strike days but also retained good relationships with their staff throughout. It was encouraging to see that the RCN and the Government were starting negotiations but important to note that members of other trade unions were still involved in industrial action. Attendees were advised of the changes to public behaviour on strike days with calls to 999 reduced by 9%. **System Pressures** At the January 2023 Board meeting there were discussions on Winter Pressures. GPU confirmed that these pressures related to all services and provided patient flow and inappropriate out of area placements in mental health services as an example.	

Item	Discussion, Outcomes and Action Points	Action by
	The Primary Care Recovery Plan was imminent, and attendees acknowledged how hard primary care colleagues were working. GP Practices were working at 110% compared to pre-Covid rates. Members commented that it would be useful to see performance data across all primary care services. **Delegation of Specialised Commissioning Services – next steps** NHS England's (NHSE) Board had approved plans to establish joint committees between NHSE and nine geographically, multi-ICB collaborations with effect from 1 April 2023. Details of footprints were appended to the report. The joint committees would be responsible for the commissioning of 59 specialised services in the first instance with a further 29 services that were suitable but not yet ready for greater ICB leadership. 89 services would remain nationally commissioned. Information relating to these services and budget details were also provided in the report. The ICB was reviewing the joint working agreement to be held between NHS England, NHS Lancashire and South Cumbria ICB and NHS Greater Manchester ICB. A further paper would be presented in March 2023 to seek approval of the arrangements and establishment of the Joint Committee as a formal committee of the ICB, including ICB membership of the Committee. **System Pressures with specific reference to Mental Health Services** Increased demand, acuity and complexity of cases continued to cause system-wide pressure and impact on mental health acute care flow. As an example of the escalating requirement for MH services, the system had seen an increase in Adult Crisis line calls from 350 per week from September to December 2021 to 500 calls per week for the same period in 2022. **Future changes to ICB Governance arrangements** At its meeting in March 2023, the ICB Board would receive formal proposals around changes to ICB Governance arrangements, which included seeking the approval of the establishment of a number of new Committees of the ICB. The ICBs Finance, Investment and Our Resources Committee would also be looking to approve the establishment of a Workforce Sub-Committee that will focus on the ICBs workforce. **ACTION: CWA confirmed that a further report would be presented to the Board in March 2023 that would include the terms of reference for these new Committees** **The Integrated Care Board:** • **noted the contents of the report** • **formally noted the appointments to the ICB Board as appended to the report**	CWA
ICB/01/23/07	**Report of the Knowsley Place Director (Alison Lee)**	
	The Board considered a presentation by Alison Lee. The presentation provided information on the visions and values of firstly	

Item	Discussion, Outcomes and Action Points	Action by
	the NHS through its Long-Term Plan, the Cheshire and Merseyside Health Care Partnership Strategy and Knowsley Healthier Together. Demographics relating to Knowsley were shared and these highlighted current and projected general population growth and data relating to the borough's ageing population. It was good that the population was growing, however there were underlying health issues due to the levels of deprivation in Knowsley. The top health challenges for Knowsley included depression, obesity, long-term conditions, population smoking rates and life expectancy, with the latter having decreased by 2 years in the last 2 years. Women lived to the average age of 81 and men to 77. This was lower than North West and Cheshire and Merseyside averages. The top health challenges were mainly around avoidance. Information about Knowsley Healthier together was provided showing that it was a placed-based partnership that addressed the critical health challenges and embraced the opportunities to improve health services across the Borough. The slides then provided examples of the organisation's achievements for 2022/23 with urgent care and primary care being highlighted specifically. The number one focus for residents was access to GP services ALE finished with details covering the organisation's approach to meaningful engagement and communication with its communities, it is governance arrangements and key objectives. After listening to residents Place had made a revised offer and this was included in the pack. **The Integrated Care Board noted the presentation and thanked Alison for the warm welcome to Knowsley Place.**	
ICB/02/23/08	**Resident Story**	
	ALE read through a resident's account of her family's experiences of using the Urgent Community Response and Rapid Response service. It detailed how a local family had hit crisis point with two elderly parents with health needs. Dad had Alzheimer's and had suffered a heart attack recently and Mum was very ill with a heavy cough and flu like symptoms. She was prescribed antibiotics in tablet form but was unable to digest them and was losing weight rapidly. The only option that the family believed was open to them was for her to be admitted to hospital and they did not want this to happen. The Urgent Community Response and Rapid Response visited their home and assessed both parents. The team gave the family critical advice on how to help Mum and gave her medication in liquid form which she was able to take. They attended the family home over several days until Mum was in a more stable condition. The family reported that it was a huge relief to have a medical professional visit and provide health checks. They had no doubt that this kept Mum out of hospital and saved them from losing her completely.	

Item	Discussion, Outcomes and Action Points	Action by
	The family finished by sending their heartfelt thanks to the Urgent Community Response and Rapid Response team. Partnership working, especially with the local authority, was key to the success of schemes such as these. Strengthening relationship with the voluntary sector, PCNs and Healthwatch was also extremely important. ALE added that as a Place Director the ICB executive team met weekly, and she was also part of that team. **The Integrated Care Board noted the presentation and extended its thanks to ALE and the family for sharing their experiences.**	
11.20am	**ICB Key Update Reports**	
ICB/02/23/09	**Executive Director of Nursing & Care Update Report (Christine Douglas)**	
	CDO's report provided assurance from the Executive Director of Nursing & Care to the Cheshire and Merseyside (C&M) Integrated Care Board (ICB) on the quality, safety and patient experience of services commissioned and provided across the geographical area of C&M. The report updated on: **Industrial Action** – Preparation and planning had been ongoing since the first wave of industrial action through the clinical/workforce cell that met twice weekly. The ICS had also established a governance framework that aligned to both national and regional architecture. **Health Equity Collaborative for Children & Young People** – as a result of successful bidding, the ICS was working with Barnardo's and the Institute of Health Equity. The programme would help to shape the way the ICS addressed health inequalities among children and young people. Further updates would be brought to the Board. **Training Support Package for Nurses in Residential Care Sector –** Additional funding of £330k had been secured to develop a programme of education for those nurses currently working within the residential care sector. The monies must be used to support interventions that would help to avoid admission/aid discharge from acute hospital settings. The system was investigating where best to target this funding. Further updates would be brought to the Board. **SEND –** Warrington Place had undergone an inspection and was one of the first in the country to do so under the new inspection regimes. Further updates would be brought to Board once the inspection outcome had been received. **System Oversight Framework (SOF) Cheshire and Wirral Partnership (CWP) NHS FT -** CWP's challenges had previously been advised to the Board. Further to a recent segmentation moderation exercise, in line with the NHS Oversight Framework 2022/23, a more focused review had been undertaken. As a result of this CWP had been moved from Segment 1 to Segment 2. NHSE and the ICB would continue to support CWP to progress	

Item	Discussion, Outcomes and Action Points	Action by
	to a Segment 1 rating. **The Integrated Care Board noted the Executive Director of Nursing & Care Update Report.**	
ICB/02/23/10	**Cheshire & Merseyside System Month 10 Finance Report (Claire Wilson)**	
	The report updated 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. CWI highlighted that for the period ending 31st January 2023 (Month 10), the ICS (System) was reporting an aggregate deficit of £63.6 year to date against a planned deficit of £34m resulting in an adverse year to date variance of £29.6m. This was an improvement of £7.3m on the position reported a month 9. The system continued to forecast achievement of the annual planned deficit of £30.3m and the £7m favourable variance to plan for providers offset the £7m unfavourable variance for the ICB and reflected achievement of a provider stretch target included during planning in the ICB position. Detailed work had been undertaken to review forecasts at individual organisation level and updated positions were reflected in the report. The system continued to forecast a position in line with its plan by year end. Key to this was the reliance on non-recurrent measures and focus remained on delivery of non-recurrent efficiencies in the future CWI explained to the Board that under the Capital Programme for individual providers, organisations had spent £112m to month 10 on capital and would spend £220m by the end of the year, that is in month 11 and 12. This profile was not unusual for NHS organisations. CWI confirmed that providers had confirmed that the funding would be spent by the end of the financial year. If there was a surplus at year end there could be consideration on the potential to move money across sectors. Attendees discussed how provider agency costs and industrial action impacted on figures. The system was challenging and working with those providers with large agency costs. The assessment to date was an unmitigated £36.9m deficit. This could improve due to depreciation funding, an increase in interest rates and additional funding. The system was undertaking work to mitigate the risk in full by the end of the year, but it remained a significant challenge. **The Integrated Care Board noted the Cheshire & Merseyside System Month 10 Finance Report.** **ACTION: CSA/CDO to bring further information to the Board around non-contracted staff to allow for a better understanding of the issue**	CSA / CDO

Item	Discussion, Outcomes and Action Points	Action by
ICB/02/23/11	**Cheshire & Merseyside ICB Quality and Performance Report (Anthony Middleton)**	
	AMI provided an update on the Cheshire and Merseyside (C&M) ICB Quality and Performance Report. This included an overview of key sentinel metrics drawn from the 2022/23 Operational plans, specifically Urgent Care, Planned Care, Cancer Care, Mental Health and Primary Care. A number of key areas and risks were highlighted. **Urgent and emergency care system** - continued to experience significant and sometimes severe pressure across the whole of C&M. In January, the system had reported an Operational Pressures Escalation Level 4, but this had reduced to Level 3 recently. Winter plans had included additional national funding to open 205 more beds over the course of the winter. The trajectory called for 161 of these beds to be open by the end of December. In practice 194 of these beds were open as at the end of December, and by the end of January all 205 were open. Winter de-brief work would be completed shortly, and a report brought to the Board meeting in April 2023. Attendees commented on a system that appeared to be in crisis and referred to long ambulance handover times and A&E waits, patients being treated in corridors and delays in admissions, and problems experienced in social care providers. It was only when all data was triangulated could the system look to address issues. AMA provided an example of bed occupancy rates of over 100% and the effect this had across other parts of the system. Members discussed the impact on stress levels of staff working under these conditions and that this should be acknowledged. **Elective care and diagnostics** – the system was still on track to eliminate 78 week waits by the end of March 2023. **Performance Reports** - GPU commented that the Board received a huge amount of information in this report and on occasions it might be necessary to qualify some data. Where graphs showed the C&M performance against the England average it was important to note that the ICS was the second largest in the county. This was important if the information was based on volume. For future reports it would be useful to present three or four of the sentinel metrics and describe what the ICB was doing to address these before being brought to the Board. **Primary Care Dashboard –** attendees questioned the data listed on the dashboard and discussed digital solutions to appointment waiting times, preparedness for future Covid waves, and virtual wards and their effectiveness. Members also referred to the data displayed under the heading ‘number of general practice appointments per 10,000 weighted patients’ and asked if these could be separated into appointments with GPs, nurses and other	

Item	Discussion, Outcomes and Action Points	Action by
	healthcare professions such as community pharmacists. AMI and AIR confirmed that work to do this was already underway. By way of assurance, attendees were advised that detailed conversations around these issues were taking place at the Primary Care Committee. RJA summarised that taken in isolation there were some concerning data points. Quality and Performance Committee had the remit to review and escalate issues listed in the report to the Board where appropriate. The Board's role was to receive assurance and the executive team were asked to consider how best this could be managed. Reference was made to the electronic version of the report that was sent to Board members that allowed individuals to deep dive into areas that concerned them. **The Integrated Care Board noted the contents of the report and took assurance on the actions contained.**	
	ICB Business Items	
ICB/02/23/12	**Cheshire & Merseyside ICB Equality Diversity and Inclusion Annual Report 2022 – 2023**	
	CWA presented the streamlined Annual Equality, Diversity & Inclusion report 2022/23 for consideration. The document provided assurance that specific and regulatory requirements were being met and also reflected that the organisation was still undertaking a major restructure process. The Annual report included: • Headline equality information and activity that has taken place across the ICB since July 2022, in its role as a leader, employer and a commissioner. • Available and proportionate Equality information. • ICB proposed preliminary one year Equality Objectives. • Highlight the approach taken to implementing the Equality Delivery System 2022, Domain one. • Equality Delivery Systems 2022 summary report Domain one. Once the EDI Annual report and EDS 2022 Summary were noted and the one-year ICB Equality Objectives were approved all documentation would be published on the ICB's website. The EDS 2022 provided for 11 outcomes over the three domains of Commissioned and Provider services, Workforce health and wellbeing and Inclusive Leadership. In domain one the ICB was achieving. Domains two and three were linked to the staff survey and would be reported on at the ICB Board meeting in April 2023. **ACTION: CWA to present on the results of the Staff Survey at the April Board meeting.** Equality Objectives 2023/2024 had been set for a one-year period as opposed to four years. These would focus on key priorities and allow time for the organisation to develop as it matured and also flexibility to change objectives if required.	CWA

Item	Discussion, Outcomes and Action Points	Action by
	CDO talked further about the EDI report, the three domains and the importance of using the results from the staff survey when published on 9th March 2023. The ICB would publish on areas such as the gender pay gap, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). It was recognised that the report followed a national format but that there was a need to put this in the context of a local framework and provide ICB specific action plans. If staff were not representative of the communities, they serve then this could be problematic. RJA highlighted that the Board was being asked to approve four Equality objectives with the final one reading as to 'Empower and engage our leadership and workforce'. This needed to be more explicit to say addressing overall inequalities. **ACTION: CWA confirmed that this would be amended to reflect the conversation and forward to Members following the meeting for their approval.** **The Integrated Care Board**: • noted the Equality Diversity & Inclusion Annual Report (Appendix One) including proportionate equality information. • note the approach taken to implement the EDS 2022, Domain one (Appendix One, section five). noted the EDS 2 Summary report for Domain One and the score of Achieving. (Appendix Two) • approved the annual ICB proposed Equality Objectives 2023 to 2024 (Appendix One, section six) subject to the amendment the fourth Equality objective (Empower and engage our leadership and workforce) explicitly showing 'to address overall inequalities'.	CWA
ICB/02/23/13	**Cheshire & Merseyside ICB Risk Management (Clare Watson)**	
	MCU and DBO presented the ICB Risk Management Strategy for review and approval. The establishment of effective risk management systems was vital to the successful management of the organisation and the local NHS system and was recognised as being fundamental in ensuring good governance. The strategy had been developed on behalf of the ICB based on best practice and subject to consultation within the ICB and with its internal auditors. The key components of the Risk Management Strategy were described in in the report and illustrated in appendix two to the document. Attention was drawn specifically to responsibilities in relation to the strategy. The Board Assurance Framework (BAF) was an important tool to enable the Board to deliver its responsibilities and the proposed reporting was described in section 4 and illustrated in appendix three to the report.	

Item	Discussion, Outcomes and Action Points	Action by
	ACTION: The proposed format of the BAF and the final Risk Appetite document would be considered at the April 2023 Board meeting. Comments from attendees included: • acknowledgement that this was a fundamental document for the organisation and that these documents should be a driver for the organisation. • that the ICB should be able to operate effectively on 20 or fewer strategic risks • the question on how providers could be encouraged to contribute to the plans without duplicating work across the system • how would a system level framework be managed thoughts on the implementation of the strategy and training of staff that the new Risk Committee would help to address these questions and concerns **The Integrated Care Board:** • **approved the Risk Management Strategy attached at Appendix One** • **approved the proposed Board Assurance Framework report format** • **approved the core statement and risk appetite definitions included in the draft Risk Appetite Statement** • **noted the work being undertaken to populate the Board Assurance Framework and the further input that will be requested from Board members to complete the detailed risk appetite statement.**	MCU
ICB/01/23/14	**Cheshire & Merseyside ICB Prioritisation Framework (Clare Watson)**	
	The report presented by CWA outlined work that had taken place to develop a prioritisation framework (that included the commissioning and de-commissioning of services) for Cheshire and Merseyside Integrated Care System. Members were advised of the approach being taken to develop the framework and of progress made to date for the 2023-24 plan. The next steps included consideration at stakeholder and public engagement sessions. This included the Health and Care Partnership workshop on 7 March 2023. The development of the final prioritisation framework was reaching conclusion and following this there would be a further set of workshops that would include the voluntary and third sector. The prioritisation process had been built around areas identified as strategic objectives within the interim Health and Care Partnership Strategy. Reducing Health Inequalities was the key driver behind both the phases of work described in the paper. Comments received included: • that the ICS had been given priorities by Government, but it was for the ICS to decide how to implement these. We need to be explicit that principles also applied to the Provider Collaborative • reference to the four core objectives of the ICS and that there was a	

Item	Discussion, Outcomes and Action Points	Action by
	concern that if everything was a priority then nothing was a priority. • the framework would underpin the development of a joint forward plan of key decisions. This would be finalised by June 2023 for sign-off at the nine Health and Wellbeing Boards • the cross-over between the ICB Board and the role of the HCP in developing priorities was discussed. The interim strategy was an HCP document, and the intention was for the prioritisation tool to be robust enough to cover all elements of the ICS. • the framework would help bring today priorities across the ICS, but that significant engagement work was required through the workshops referred to in the report • there was also a need for all nine Place to be represented on the Prioritisation Panel. Membership on the panel would be key. **ACTION: CWA confirmed that that the Prioritisation Framework would be presented to the ICB Board in at its April 2023 meeting.** **The Integrated Care Board noted the contents of the report including next steps**.	CWA
ICB/01/23/15	**Update on NHSE Primary Care Delegation to Cheshire & Merseyside ICB (Clare Watson)**	
	The Board received an update on the transfer of delegated commissioning responsibility for general ophthalmic services and primary, community and secondary care dental services. CWA advised that the ICB assumed responsibility for Community Pharmacy services in July 2022 and responsibility for Ophthalmic and Dental Services would transfer in April 2023. The ICB had been working closely with the NHSE Regional Team on a process of assurance to support the safe delegation of Ophthalmic and Dental Services. This included discussions to enable effective operating and governance models for the delegated functions. Members were provided with details on the due diligence work already undertaken and that which was on-going, a list of the services that would be transferring and a list of issues and priorities that would be inherited. Commissioning budget and increases (c£280m) were referred to as where the risks. Work would continue through the Primary Care Committee. **ACTION: A further update report on delegated services would be presented to the Board in six months**. **The Integrated Care Board:** • **noted the update regarding the delegation of Ophthalmic and Dental Services to the ICB on 1 April 2023. This update includes a summary of the areas, the budget and provides associated supporting documents in the Appendices.** • **noted a full breakdown of the financial elements will be included in the draft financial plan that will be shared with the ICB on 10 February 2023.** • **noted the reported risks to delegation highlighted through the Pre-**	CWA

Item	Discussion, Outcomes and Action Points	Action by
	Delegation Assessment Framework (PDAF) process and assurances required a part of the process. • **Noted and supported the work undertaken to date in relation to the delegation of Ophthalmic and Dental Services on 1 April 2023.**	
ICB/01/23/16	**Cheshire & Merseyside Health and Care Partnership Chairs Report**	
	The summary report informed the Board of the discussions undertaken at the January 2023 meeting of the Cheshire and Merseyside Health and Care Partnership (HCP). The Chair asked members to take the report as read and commented that it was pleasing to see all partners coming together for a common cause. **The Integrated Care Board noted the summary report of the discussions undertaken by the Health and Care Partnership Committee at its January 2023 meeting.**	
ICB/01/23/17	**Liverpool Women's Services Programme Update**	
	The report presented by CDO provided an update to the Board on progress in establishing a programme to take forward the recommendation in the Liverpool Clinical Services to address the clinical sustainability challenges affecting women's health for people across who access the services provided by Liverpool Women's Hospital. These services were provided for people in Merseyside, Cheshire and beyond. The recommendations from the Liverpool Clinical Services review had been considered by the ICB at its January 2023 meeting. The objective of the review was to realise opportunities for greater collaboration between acute and specialised trusts to optimise clinical pathways in acute care in Liverpool. This programme, to address the clinical sustainability challenges affecting women's health, was one of three critical priorities identified through the review. There had been significant work undertaken to date and there had been a large amount of public interest in the item culminating with a 60k plus petition that was submitted to the ICB Board meeting in January 2023. A number of Board members had met with representatives of Liverpool Women's Hospital Group to listen to concerns and questions. It was a beneficial meeting, and they would continue to hold these meetings. The new sub-committee was to be established with a role to oversee the development of a future care model. This would include non-executive directors, executive directors, representatives from NHS Trusts and dependent services, Healthwatch and patients with lived experiences. **The Integrated Care Board:** • **noted the update on progress in establishing this programme** • **noted that patient and public engagement will be integral to all phases of the programme and that this is an open process, with no decisions made about the future delivery model for these services.**	
	Sub-Committee Reports	

Item	Discussion, Outcomes and Action Points	Action by
ICB/01/23/18	**Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee**	
	The report provided assurance to the Board in regard to key issues, considerations, approvals and matters of escalation considered by the Quality and Performance Committee. Members were asked to take the report as read but TFO highlighted two items listed: • Local Maternity & Neonatal System Report (LMNS) – important to note the work undertaken by CDO and that LMNS reported to the committee on a monthly basis • Risk Register Update – currently in draft format. The Board was asked to approve the Clinical Policy Harmonisation legacy policies. **The Integrated Care Board:** • **noted the content at Section 2** • **noted the content and the issues considered by the Committee and actions taken at Section 3** • **noted that no matters required escalation to the ICB Board** • **approved the legacy policies as described at Section 5 of the report**	
ICB/01/23/20	**Report of the Chair of the Cheshire & Merseyside ICB Finance, Investment and Our Resources Committee (Erica Morriss)**	
	CWI advised the Board that the committee had met on 25th January 2023. The main items considered at the meeting included: • Review of Committee Workplan and Terms of Reference. The Board was asked to approve the revised Terms of Reference • Month 9 ICB / ICS Finance Report • Update on Financial Governance / Operational SORD • Update on ICB Organisational Change Process • 2023/24 Planning. The next meeting of the Committee was scheduled to be held on 21st February 2023. **The Integrated Care Board** • **noted the items covered by the Committee** • **noted that the committee considered the month 9 financial position of the ICB/ ICS in respect of both revenue and capital allocations** • **noted that updates were received in respect of a number of other areas as listed** • **approved the updated Committee Terms of Reference.**	
1.40pm	**Other Formal Business**	
ICB/01/23/21	**Closing remarks, review of the meeting and communications from it (Raj Jain)**	
	The Chair thanked the Board for their participation in the meeting. The communications team would compile a summary of the meeting. The	

Item	Discussion, Outcomes and Action Points	Action by
	papers were currently available online and a recording of proceedings would be added following the meeting.	
	CLOSE OF MEETING	
Date, time, and location of Next Meeting:		
30 March 2023 (time to be confirmed), The Boardroom, The Department, Lewis's Building, 2 Renshaw Street, Liverpool, L1 2SA		

End of Meeting

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2022-23

Updated: 22 March 2023

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-22-05	27/10/2022	**Continuous Glucose Monitoring Update**	Requested that in 12 months' time the Board be provided with a progress update.	Rowan Pritchard-Jones	01-Oct-2023	Added to the forward plan	ONGOING
ICB-AC-22-06	27/10/2022	**Provider Collaborative Update**	Agreed that a strategic business case relating to increased delegation be brought to the Board for consideration.	Joe Rafferty	28-Nov-2022	Added to work plan for May 2023	ONGOING
ICB-AC-22-10	28/11/2022	**Cheshire & Merseyside System Month 7 Finance Report**	There was a need for a comprehensive provider organisational integrated performance report to be presented to the Board covering all challenges being faced by organisations. This would be provided in the new financial year.	Claire Wilson	April 2023	Added to work plan for May 2023	ONGOING
ICB-AC-22-11	28/11/2022	**Cheshire & Merseyside System Month 7 Finance Report**	In the absence of a comprehensice provider organisational integrated performance report, members would be sent dashboards that provided the wider financial position and workforce information.	Claire Wilson	Jan 2023		ONGOING
ICB-AC-22-13	28/11/2022	**ICB Equality, Diversity and**	Members discussed how data collected via WRES, WDES, CORE20, EDS2 and other system would be used and shared with the Board. IAS agreed to bring a further report on Core20Plus to a future Board meeting in relation to this.	Chris Samosa	TBC		ONGOING
ICB-AC-22-14	28/11/2022	**Consensus on the Primary Secondary Care Interface**	PRJ confirmed that discharge medicines services were crucial for patients and a future paper would be required at Board to review	Rowen Pritchard-Jones	TBC	Has been added to the Board Forward Plan	ONGOING
ICB-AC-22-15	28/11/2022	**Consensus on the Primary Secondary Care Interface**	An update report would then be presented to Board over the next 12 months	Rowen Pritchard-Jones	TBC	Has been added to the Board Forward Plan	ONGOING
ICB-AC-22-18	28/11/2022	**Report of the Chair of the Cheshire & Merseyside ICB Primary Care Committee**	The Primary Care Strategy. This would be presented to the Board in March 2023	Clare Watson	Mar 2023	Added to work plan for April 2023	ONGOING
ICB-AC-22-20	23/01/2023	**NHS 2023/24 Priorities and Operational Planning Guidance**	that the submission date for the draft operational plan prevented it from being approved by the Board before submission on 23 February 2023 and as such there was a need for review by the ICB Executive Team and Provider Collaboratives. The final submissions would be presented to the Board for approval in March 2023	Clare Watson	March 2023	Added to work plan for March 2023	ONGOING

Action Log 2022-23

Updated: 22 March 2023

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-22-21	23/01/2023	**Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee**	The Committee had received an Urgent Care presentation and the intention was to return to the Board meeting in March with a full Urgent Care report	Anthony Middleton	March 2023	Added to work plan for April 2023	ONGOING
ICB-AC-22-22	23/01/2023	**Report of the Chair of the Cheshire & Merseyside ICB Transformation Committee**	A programme reviewing the current transformational change activity occurring across the Cheshire and Merseyside system and the work to develop priorities, delivery, and governance approaches. A report relating to this would be presented to the Board at a future meeting	Clare Watson	March 2023	Added to work plan for April 2023	ONGOING
ICB-AC-22-23	02/03/2023	**Report of the Chief Executive**	CWA confirmed that a further report would be presented to the Board in March 2023 that would include the terms of reference for these new Committees	Clare Watson	01-Mar-2023	Added to work plan for April 2023	ONGOING
ICB-AC-22-24	02/03/2023	**Cheshire & Merseyside System Month 10 Finance Report**	CSA/CDO to bring further information to the Board around non-contracted staff to allow for a better understanding of the issue	Chris Samosa & Christine Douglas	Not specified		ONGOING
ICB-AC-22-25	02/03/2023	**Cheshire & Merseyside ICB Equality Diversity and Inclusion Annual Report 2022 – 2023**	CWA to present on the results of the Staff Survey at the April Board meeting.	Clare Watson	April 2023	Update provided at March Board on ICB Staff. Further presentationin April on system results	ONGOING
ICB-AC-22-27	02/03/2023	**Cheshire & Merseyside ICB Risk Management**	The proposed format of the BAF and the final Risk Appetite document would be considered at the April 2023 Board meeting.	Matthew Cunningham	April 2023	Added to work plan for April 2023	ONGOING
ICB-AC-22-28	02/03/2023	**Cheshire & Merseyside ICB Prioritisation Framework**	CWA confirmed that that the Prioritisation Framework would be presented to the ICB Board in at its April 2023 meeting.	Clare Watson	April 2023	Added to work plan for April 2023	ONGOING
ICB-AC-22-29	02/03/2023	**Update on NHSE Primary Care Delegation to Cheshire & Merseyside ICB Update**	A further update report on delegated services would be presented to the Board in six months	Clare Watson	September 2023	Added to work plan for September 2023	ONGOING

CHESHIRE MERSEYSIDE INTEGRATED CARE BOARD

CLOSED Actions

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-22**	**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-22**	*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*	CLOSED
ICB-AC-22-02	**01-Jul-22**	**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-22**	*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*	CLOSED
ICB-AC-22-03	**27-Oct-22**	**Cheshire & Merseyside System Month 6 Finance Report**	Requested CWA and CDO provide a Workforce Update at the next Board Meeting.	Claire Wilson	**28-Nov-22**	*Workforce Update report included within the Director of Nursing and Care Report*	CLOSED
ICB-AC-22-07	27/10/2022	**Winter Planning 2022-23**	Agreed that an updated position on winter resilience plans was reported to the Board at a future meeting	Anthony Middleton	28-Nov-2022	Winter Resilience Plan update report included on agenda for November 2022 meeting	CLOSED

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-22-08	28/11/2022	**Minutes of the previous meeting – 27 October 2022**	SBR questioned the minutes relating to item ICB/10/22/12 Provider Collaborative Update. He asked that the minute be changed to confirm that further discussions between JRA, SBR and GUR would take place but NOT that a strategic outline business case for the Collaborative to receive greater delegated responsibilities from the ICB be brought to a future meeting of the Board for consideration. RJA advised that his recollection was that the report had been requested. He confirmed that the recording of the meeting would be reviewed and confirmation of the agreed action be shared.	Raj Jain	Jan 2023	*Action completed*	CLOSED
ICB-AC-22-04	27/10/2022	**Executive Director of Nursing and Care Report - Recommendations within the Kirkup Report**	An independent investigation was commissioned in February 2022, reviewing 202 cases, evidence from family listening sessions, clinical records, interviews with clinical staff. Agreed to take the Kirkup recommendations to the Quality Committee for consideration.	Christine Douglas	28-Nov-2022		CLOSED
ICB-AC-22-09	28/11/2022	**Executive Director of Nursing & Care Report**	CDO confirmed that the C&M People Board was operational and that there was a need for robust plans to be developed to support this area of work. Early considerations included potential rostering issues and the introduction or continuation of flexible working arrangements Requested a report to January 2023 to describe if and how arrangements had been successful	Christine Douglas	Jan 2023	Update report on March Board	CLOSED
ICB-AC-22-12	28/11/2022	**Cheshire & Merseyside ICB Quality and Performance Report (Anthony Middleton)**	RJA requested that the Cheshire and Merseyside Cancer Alliance be invited to the January 2023 meeting to explain its work programme	Rowan Pritchard-Jones	Jan 2023	Update report on March Board	CLOSED
ICB-AC-22-16	28/11/2022	**Winter Planning 2022-2023 Update**	Requested that Cllr Louise Gittins, as Chair of the Cheshire and Merseyside Health and Care Partnership, receive a report on Place Based Winter Planning	Anthony Middleton	TBC	*Completed. Report circulated to Cllr Gittens*	CLOSED

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-22-17	28/11/2022	**Report of the Chair of the Cheshire & Merseyside ICB Primary Care Committee**	An update on dentistry and optometry. A full formal report on dentistry would be presented to Board in February 2023.	Clare Watson	Feb 2023	Came to February Board	CLOSED
ICB-AC-22-19	23/01/2023	**Cheshire & Merseyside System Month 9 Finance Report**	GUR questioned the agency spend performance and outturn forecast. He asked how these figures compared to pre-pandemic levels and to performance against other ICS areas. CWA was asked to provide this information in future reports.	Claire Wilson	01-Feb-2023	CWI confirmed that the reports now included this information	CLOSED
ICB-AC-22-26	02/03/2023	**Cheshire & Merseyside ICB Equality Diversity and Inclusion Annual Report 2022 – 2023**	CWA confirmed that the following would be would be amended to reflect the conversation and forwarded to Members following the meeting for their approval: 'Empower and engage our leadership and workforce'. Needed to be more explicit to say addressing overall inequalities.	Clare Watson	March 2023	Amendments made and approved by Board members following the meeting	CLOSED

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2023

Cheshire and Merseyside

Updated: 23 March 2023

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

Decision Log 2022 - 2023

NHS Cheshire and Merseyside

Updated: 23 March 2023

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-10	04-Aug-2022	**Cheshire & Merseyside ICB Financial Plan/Budget**		1) The Board supported the financial plan submission made on 20th June 2022 in relation to the 2022/2023 financial year. 2) The Board approved the initial split for budgetary control purposes between 'central ICB' and 'Place' budgets for 2022/23 resulting in a headline 20%/80% split respectively.	
ICB-DE-22-11	04-Aug-2022	**Cheshire & Merseyside System Month 3 (Quarter One) Finance Report**		The Board noted the Month 3 Financial Report.	
ICB-DE-22-12	04-Aug-2022	**Cheshire & Merseyside Month 3 (Quarter One) Performance Report**		The Board noted the Month 3 Performance Report and requested that the next report includes data around mental health indicators and the wider primary care service.	
ICB-DE-22-13	04-Aug-2022	**Establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire**		The Board approved the clinical case for the establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire subject to an ongoing financial review.	
ICB-DE-22-14	04-Aug-2022	**Virtual Wards – update on their expansion across Cheshire and Merseyside**		The Board noted the Virtual Wards update.	
ICB-DE-22-15	04-Aug-2022	**Responses to questions raised by Members of the Public in relation to items on the agenda**		The Board agreed to respond to all public questions raised prior to the August meeting.	
ICB-DE-22-16	29-Sep-2022	**Chief Executive Report**		1) The Board approved entering into the Sefton Partnership Board Collaboration Agreement 2) The Board approved the recommendation to delegate authority to the Chief Executive and the Assistant Chief Executive to sign off collaboration agreements or memorandum of understanding from other places noting that any arrangements requiring S75 or pooled budget agreements would be submitted to the ICB Board for approval.	
ICB-DE-22-17	29-Sep-2022	**Liverpool University Hospitals NHS Foundation Trust Clinical Service Reconfiguration Proposal**		1) The Board approved the proposals for the five LUHFT major service changes, which are contained in a business case (and outlined in Section 4 of this paper) and informed by a formal public consultation 2) The Board noted the decisions of NHS England against the proposals for the four of the five service areas (vascular, general surgery, nephrology and urology) that are in the scope of NHS England commissioning responsibilities.	
ICB-DE-22-18	29-Sep-2022	**Developing the Cheshire and Merseyside Integrated Care Partnership (ICP)**		1) The Board approved the appointment of Louise Gittins as the designate Chair of the ICP 2) The Board approved the process for the appointment of a vice chair	
ICB-DE-22-19	29-Sep-2022	**Report of the Audit Committee Chair**		1) The Board approved the Committee recommendation to agree the proposed amendments to the Terms of Reference of the ICB Audit Committee 2) The Board approved the Committee recommendation to appoint an ICB Counter Fraud Champion and the stated named post to undertake this role 3) The Board approved ICB Information Governance Policies and statements / Privacy notices and their subsequent publication	
ICB-DE-22-20	29-Sep-2022	**Report of the Chair of the ICB Quality and Performance Committee**		The Board approved the proposed amendments to the revised Terms of Reference for the ICB Quality & Performance Committee	
ICB-DE-22-21	29-Sep-2022	**Report of the Chair of the ICB System Primary Care Committee**		The Board approved the proposed amendments to the Committees Terms of Reference subject to membership from LPS being included.	
ICB-DE-22-22	27-Oct-2022	**Chief Executive Report**		1) The Board noted the contents of the report. 2) The Board approved the recommendation change in the ICB's named Freedom to Speak Up Guardian.	
ICB-DE-22-23	27-Oct-2022	**Welcome to Cheshire East**		The Board noted the contents of the report and presentation.	
ICB-DE-22-24	27-Oct-2022	**Residents Story Update - Social prescribing**		The Board noted the presentation.	
ICB-DE-22-25	27-Oct-2022	**Cheshire & Merseyside System Month 6 Finance Report**		1) The Board noted the contents of this report in respect of the Month 6 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year. 2) The Board requested CWA and CDO provide a Workforce Update at the next Board Meeting.	
ICB-DE-22-26	27-Oct-2022	**Cheshire & Merseyside ICB Quality and Performance Report**		The Board noted the contents of the report and take assurance on the actions contained.	
ICB-DE-22-27	27-Oct-2022	**Executive Director of Nursing and Care Report**		1) Noted the content of the report. 2) Noted that CDO would be taking the Kirkup recommendations to the ICB Quality and Performance Committee for consideration. 3) Noted that a Workforce update will be provided within the next Director of Nursing and Care report to the Board Meeting.	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2023

Cheshire and Merseyside

Updated: 23 March 2023

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-28	27-Oct-2022	**Continuous Glucose Monitoring**		1) The Board approved the retirement of the current Cheshire & Merseyside Continuous Glucose Monitoring (CGM) policy, and 2) The Board approved the recommendations for CGM and flash glucose monitoring within NICE NG17, NG18 and NG28. 3) Requested that in 12 months' time the Board be provided with a progress update.	
ICB-DE-22-29	27-Oct-2022	**Provider Collaborative update**		1) Noted the content of the report. 2) Agreed that a strategic outline business case for the Collaborative to receive greater delegated responsibilities from the ICB be brought to a future meeting of the Board for consideration.	
ICB-DE-22-30	27-Oct-2022	**System Finance Assurance Report**		The Board noted the contents of the report and the development of the financial accountability framework.	
ICB-DE-22-31	27-Oct-2022	**Winter Planning 2022-23**		1) The Board noted the contents of this report for information. 2) The Board agreed that an updated position on winder resilience plans is reported to the Board at a future meeting	
ICB-DE-22-32	27-Oct-2022	**Report of the Chair of the Cheshire & Merseyside ICB Remuneration Committee**		1) The Board noted the items covered by the Remuneration Committee. 2) The Board approved the recommendation to agree the proposed amendments to the Terms of Reference of the ICB Remuneration Committee (Appendix A).	
ICB-DE-22-33	27-Oct-2022	**Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee**		The Board noted the contents of the report.	
ICB-DE-22-34	27-Oct-2022	**Report of the Cheshire & Merseyside Chair of the ICB Transformation Committee**		1) The Board noted the report 2) Approved the revised terms of reference attached to the paper.	
ICB-DE-22-35	28-Nov-2022	**Cheshire and Merseyside ICS Digital Strategy**		Endorsed the ICS Digital and Data Strategy with a view to formal approval at a subsequent ICB Board meeting.	
ICB-DE-22-36	28-Nov-2022	**Consensus on the Primary Secondary Care Interface**		Endorsed the consensus Agreed on the proposed actions for implementation: ongoing promotion to Secondary Care via the Trust Medical Directors recommendation for the formation of Primary Secondary Care Interface Groups based around Acute Trusts across Cheshire and Merseyside	
ICB-DE-22-37	28-Nov-2022	**Report of the Chair of the Finance, Investment and Resources Committee**		Approved the revised terms of reference attached to the paper	
ICB-DE-22-38	23-Jan-2023	**Report of the Chief Executive - Harmonising Clinical Commissioning Policies Update**		Approved the revised Legal statement as detailed within Appendix Two, as reviewed by Hill Dickinson	
ICB-DE-22-39	23-Jan-2023	**Review of Liverpool Clinical Services**		Noted the content of the report Agreed all the recommendations within the report; however with regards those recommendations to be overseen by CMAST the Board removed from the recommendations the sentence 'the starting point for realising the opportunities identified in this review should be the 6 organisations within Liverpool.' Only once tangible progress is made within this scope should it be broadened to a wider geography Agreed the implementation plan and associated timescales	
ICB-DE-22-40	23-Jan-2023	**Cheshire & Merseyside Integrated Care Partnership Interim Draft Strategy 2023-24**		Noted the contents of the draft interim strategy Endorsed the next steps agreed by the Health and Care Partnership at the meeting of 17 January 2023; including the ICB using the priorities within the draft interim strategy to inform development of the ICB Five Year Joint Forward Plan	
ICB-DE-22-41	23-Jan-2023	**NHS 2023/24 Priorities and Operational Planning Guidance**		Noted: The content of the 2023-24 NHS planning guidance, including the need to develop both 2-year operational plans and an ICB Joint Forward Plan The approach to developing our Cheshire and Merseyside plans including the role of providers in developing and approving plans as well as the need to engage with the HCP partners and HWB in developing the content of the plans. That the submission date for the draft operational plan prevented it from being approved by the Board before submission on 23 February 2023. The need for review by the ICB Executive Team and Provider Collaboratives before submission and review, and ratification at the February Board meeting which takes place on the day of submission. That the final submissions would be presented to the Board for approval in March 2023	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2023

NHS Cheshire and Merseyside

Updated: 23 March 2023

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-42	23-Jan-2023	**Report of the Chair of the Cheshire & Merseyside ICB Audit Committee, including amendments to the ICB SORD & SFIs**		Noted the items covered during the Audit Committee of 13 December 2022 report. Approved the Operational Scheme of Delegation Update, December 2022	
ICB-DE-22-42	02-Mar-2023	**Cheshire & Merseyside ICB Equality Diversity and Inclusion Annual Report 2022 – 2023**		Approved the annual ICB proposed Equality Objectives 2023 to 2024 (Appendix One, section six) subject to the amendment the fourth Equality objective (Empower and engage our leadership and workforce) explicitly showing 'to address overall inequalities'. Fourth Objective agreed virtually by Board members post February meeting	
ICB-DE-22-42	02-Mar-2023	**Cheshire & Merseyside ICB Risk Management**		Approved the Risk Management Strategy attached at Appendix One Approved the proposed Board Assurance Framework report format Approved the core statement and risk appetite definitions included in the draft Risk Appetite Statement	
ICB-DE-22-42	02-Mar-2023	**Update on NHSE Primary Care Delegation to Cheshire & Merseyside ICB**		Noted and supported the work undertaken to date in relation to the delegation of Ophthalmic and Dental Services on 1 April 2023	
ICB-DE-22-42	02-Mar-2023	**Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee**		Approved the legacy policies as described at Section 5 of the report	
ICB-DE-22-42	02-Mar-2023	**Report of the Chair of the Cheshire & Merseyside ICB Finance, Investment and Our Resources Committee**		Approved the updated Committee Terms of Reference	

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Chief Executive's Report

30 March 2023

Agenda Item No	**ICB/03/30/07**
Report author & contact details	Graham Urwin, Chief Executive
Report approved by (sponsoring Director)	-
Responsible Officer to take actions forward	Graham Urwin, Chief Executive

Chief Executive's Report (March 2023)

Executive Summary	This report provides a summary of issues not otherwise covered in detail on the Board meeting agenda. This includes updates on: • Quarter 3 Assurance letter from NHS England • Running Cost Allowance – efficiency requirements • Hewitt Review • Update on the return of maternity services to Macclesfield Hospital • Changes to the GP Contract in 2023/24 • Innovator site status for CMAST Provider Collaborative • HSJ Awards • Appointments update • Cheshire and Merseyside HCP Interim Strategy engagement period • Covid-19 Update • Decisions undertaken by Executives.				
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.				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
			x		
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
		x		x	
Management of Conflicts of Interest	No				
Next Steps	None				
Appendices	**Appendix One**	NHS England Letter regarding Quarter 3 Assurance Meeting			
	Appendix Two	NHS England Letter on ICB running cost allowances: efficiency requirements			

Chief Executives Report (March 2023)

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. Cheshire & Merseyside Integrated Care Board Quarter 3 Assurance

2.1 The ICB has received a letter (Appendix One) from Richard Barker, NHSE Regional Director (North West) following our recent positive Quarter 3 assurance meeting.

2.2 It was highlighted within the letter that NHS England (NHSE) felt assured that despite its challenges, the ICB had a good understanding of the systems position in terms of data, finances, performance, and delivery, and it was felt that this provided a foundation on which the ICB can build transformation, improvement and develop new ways of working.

2.3 The letter also outlined the commitment of NHSE to develop in collaboration with the ICB the exit criteria to help lead the ICB out of its System Oversight Framework (SOF) 3 rating to SOF 2.

2.4 This a positive sign of progress for the ICB and testament to the hard work and commitment of its staff and leadership teams to ensuring the ICB is a high performing and achieving organisation, dedicated to improving services and outcomes for the population of the Cheshire and Merseyside.

3. ICB running cost allowances: efficiency requirements

3.1 All ICBs have now received a letter (Appendix Two) from NHSE confirming the efficiency requirement expected of ICBs regarding running cost allowances (RCA).

3.2 Baseline RCAs for ICBs have already been held flat in cash terms in 2023/24. This has been published through the annual operational planning guidance and the supporting publication of allocations for 2023/24 to 2024/25.[1] RCA will be subject to a 30% real terms reduction per ICB by 2025/26, with at least 20% to be delivered in 2024/25. No increases to the RCA to allow for inflation in this period are anticipated. NHSE are updating the published future year RCA with three-year allocations for each ICB that reflect this 30% reduction. For Cheshire and Merseyside this equates to a c£12m reduction by 2025/26.

[1] https://www.england.nhs.uk/allocations/

3.3 An analysis is underway within the ICB to determine savings already made, our ability to reduce non-pay costs, reviewing our contracted-out services and reviewing our current vacancies to ensure that our management structure will be able to operate within the current and projected RCA without compromising our ability to meet our duties and ambitious programmes of work.

4. Hewitt Review

4.1 As colleagues are aware, Patricia Hewitt has been conducting an independent review of into how the oversight and governance of Integrated Care Systems can best enable them to succeed. The Review is still to be finalised before being submitted to the Secretary of State for publication by the end of March. I hope to be able to talk in more detail about the findings and recommendations from the review at our Board meeting this month.

5. Update on the return of maternity services to Macclesfield Hospital

5.1 At its meeting on the 16 March 2023, the Board of East Cheshire NHS Trust received and supported a paper[2] regarding the return of maternity services at Macclesfield Hospital with an expected service 'go live' date of early summer 2023. This followed receipt from the ICB of its confirmation of support, following further consideration at its Board meeting held in private in February 2023, for the return of the services following receipt of the required assurance around the successful recruitment of key staff to enable the safe return.

5.2 The Trust has a detailed implementation plan to ensure all necessary staff to be re-trained to be competent and confident to deliver a safe service from early summer and work is well underway to convert Ward 6 at the site back to a maternity ward.

5.3 The Trust is developing a robust Communications Plan to the public and will work closely with Maternity Voices Partnership (MVP). MVP and service users will also be invited to take part in a 15 Step Assessment to review the new unit from a patient perspective.

5.4 The ICB, along with colleagues from NHSE, Greater Manchester & East Cheshire Local Maternity and Neonatal System (LMNS) will continue to work with the Trust to keep appraised of the progress towards the return of the services and to deal with any issues and concerns. Christine Douglas, Executive Director of Nursing and Care will continue to be the lead Executive working with the Trust and seeking assurance.

[2] https://www.eastcheshire.nhs.uk/application/files/6716/7904/8869/Public_Trust_Board_-_16_March_2023_Numbered_Full_Bundle.pdf

6. Changes to the GP Contract in 2023/24

6.1 2023/24 is the final year of the current 5-year framework agreement. Over the course of 2023/24 NHSE will engage with GPs, patients, ICSs, government, and key stakeholders, building further on the Fuller Stocktake from May 2022 which set out the next steps towards integrating primary care. The changes to the GP contract in 2023/24 set out the goal of improving patient experience and satisfaction. These contract changes set the scene for and enable the action required within the forthcoming primary care recovery plan, which we understand will be published shortly by the Department of Health and Social Care.

6.2 Key changes to the contract include:

- the GP contract will be updated to make clear that patients should be offered an assessment of need, or signposted to an appropriate service, at first contact with the practice. The Impact and Investment Fund (IIF) focus on access will support practices and PCNs working towards achieving this during 2023.
- the GP contract will be updated so new health information is available to all patients (unless they have individually decided to opt-out or any exceptions apply) by 31 October 2023 at the latest.
- as part of the 2023/24 GP contract changes, practices will be required to procure their telephony solutions only from an NHSE published framework once their current telephony contracts expire.
- the number of indicators in the IIF will be reduced from 36 to five (worth £59m national) and will focus on a small number of key national priorities: two indicators related to flu vaccinations, learning disability health checks, early cancer diagnosis and 2-week access indicator.
- the remainder of the IIF will be worth £246m nationally and will be entirely focused on improving patient experience of contacting their practice and receiving a response with an assessment and/or be seen within the appropriate period (for example same day or within 2 weeks where appropriate, depending on urgency).
- all of the Quality Outcomes Framework (QOF) register indicators points will be awarded to practices, based on 2022/23 outturn once finalised, releasing £97m of funding nationally and reducing the number of indicators in QOF from 74 to 55 (a reduction of 25%). Two new cholesterol indicators (worth 30 points / around £36m nationally) will be added to QOF along with a new overarching mental health indicator. One indicator (AF007) will be retired and replaced with a similar indicator from IIF in 2022/23.
- this year's QOF Quality Improvement modules will focus on workforce wellbeing and optimising demand and capacity in General Practice.
- there are several changes to the Additional Roles Reimbursement scheme (ARRS), including adding Advanced Clinical Practitioner Nurses to the reimbursable roles, increasing the cap on Advanced Practitioners to three per PCN and removing the caps on Mental Health Practitioners.

- there will be changes to childhood vaccinations. These include the removal of the vaccination and immunisations repayment mechanism for practice performance below 80% coverage for routine childhood programmes along with changes to the childhood vaccination and immunisation indicators within QOF which will see a widening of the indicator thresholds.
- in recognition of the current workload pressures in general practice, no additional requirements will be added to the PCN service specifications in 2023/24. NHS England will instead publish guidance which will suggest best practice to PCNs.

6.3 Full details of the changes to the GP contract in 2023/24 can be found at: www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2023-24/

7. Cheshire and Merseyside provider collaborative named one of just nine 'innovator' sites across England

7.1 Congratulations are extended to the Cheshire and Merseyside Acute and Specialist Trust (CMAST) provider collaborative which has recently been announced as one of just nine 'innovator' sites across the country. Innovator status provides the collaborative with bespoke support from NHS England to help accelerate the work already underway to improve patient care and outcomes across Cheshire and Merseyside and enhance the resilience of local NHS services.

7.2 NHS England will work alongside each innovator site to agree a bespoke support package, including access to a sophisticated peer support offer - with best practice from the innovators scheme set to be cascaded nationally.

8. HSJ Awards

8.1 The ICB has been shortlisted as finalists for two HSJ Awards, with the awards event taking place on 23rd March.[3] The projects that have been shortlisted reflect the varied work that we are leading on in the sustainability, social value, and anchor areas.

8.2 The first Award we have been shortlisted for is the Environmental Sustainability Project of the Year, which picks up on our strong governance through the Cheshire and Merseyside Sustainability Board and are approach to delivering on goals as a system. We were Highly Commended for this at last year's awards.

[3] https://partnership.hsj.co.uk/finalists-2023

8.3 The second is the Most Impactful Project Addressing Health Inequalities, which covers our anchor and social value work, where we have developed our anchor framework and are now developing our measurement structure with our Anchor Assembly due to have its first meeting in July, and bi-monthly thereafter to ensure progress against commitment is measured. It also picks up on the fact that we are the first ICS to have a systemwide set of TOMs (Themes, Outcomes and Measures), which will give us the ability to measure the social value delivered across the ICS.

8.4 At the March Board meeting I will be able to update members on whether the ICB was successful in either of these two awards.

9. Appointments

9.1 There is a hugely rich network of academic partners and NHS (as well as social care) providers supporting research in our region. The ICB plays a crucial role in supporting the very best research to happen for the benefit of our patients, and Cheshire and Merseyside has an ambitious program of work which is determined to realise the opportunity to create an Integrated Research System alongside our partners within the Integrated Care System. To help support this the ICB has appointed Professor Terry Jones and Dr Greg Irving as Associate Medical Directors of Research.

9.2 Congratulations is also extended to Louise Shepherd CBE, the Chief Executive of Alder Hey Children's NHS Foundation Trust, who has recently been appointed as the new chair of NHS England's Children and Young People (CYP) Transformation Board.

9.3 The national CYP Transformation Board has been established to oversee delivery of Long-Term Plan commitments in relation to children and young people and comprises of key partners across health, care, and education. This is a fantastic appointment for Louise and for Cheshire and Merseyside and will no doubt further benefit our local work to improve the experiences and outcomes for our Children and Young People.

10. Cheshire and Merseyside Health and Care Partnership Interim Strategy

10.1 Cheshire and Merseyside Health and Care Partnership (HCP) has launched a survey to seek the views of our partners, people, and communities on the priorities outlined within its interim strategy.[4]

[4] https://www.cheshireandmerseyside.nhs.uk/media/jtynw5fr/cheshire-and-merseyside-health-and-care-partnership-strategy-summary.pdf

10.2 The development of Cheshire and Merseyside Health and Care Partnership provides a once-in-a-lifetime opportunity to combine our efforts and collective resources to make real improvements to the lives our people and communities.

10.3 The HCP wants to hear the thoughts and views of the public and our partners on its priorities and their experiences of living and accessing services in Cheshire and Merseyside.

10.4 People are encouraged to visit https://www.cheshireandmerseyside.nhs.uk/get-involved/share-your-views/ to review the interim strategy and answer some simple survey questions.

10.5 Feedback from the survey will be reviewed and used to finalise the HCP strategy and to develop a more detailed delivery plan (the Joint Forward Plan) by the end of June 2023.

10.6 The Board will receive at its meeting in June the Cheshire and Merseyside Joint Forward Plan for its review and approval.

11. Covid-19 Update

11.1 Following the end of the Covid booster offer the system has continued with the evergreen offer which has seen a small uptake compared to predicted for all cohorts. The latest position for Cheshire and Merseyside evergreen is 75% for first dose and 71.6% for second dose uptake compared with an uptake in the North West region of 73.3% and 69.7% respectively. The evergreen offer will continue until the 30 June 2023.

11.2 As of the 07 March 2023, Cheshire and Merseyside NHS Trust frontline Healthcare worker uptake is reported by the national team as 48.6% compared to the national and regional percentage (50.9% and 47.1% respectively). However, there remains a significant variation in the denominator used by the national team and Cheshire and Merseyside actual performance is 54%. Whilst Cheshire and Merseyside are performing better than other subregions within the North West, uptake remains disappointing and intensive work has been ongoing at each Trust to improve the position and a continued evergreen offer remains in place.

11.3 The Living well buses continue to offer evergreen vaccinations as part of their general health offer until the end of the financial year. So far, the bus has delivered 58 clinics, 49 covid vaccinations, 1385 MECC discussions, and 3380 health screenings.

11.4 On the 24 February the system received notice of a planned Spring 2023 booster campaign as part of Phase 5 of the programme. The campaign is scheduled to start with care home vaccinations form the 03 April and the older general populations 75+, housebound and 5yrs+ immunosuppressed to commence on the 17 April and end along with evergreen offer on the 30 June.

11.5 At the time of planning, the system had not received the national operating guidance, funding allocation or clinical vaccination training materials and national protocol. The operational note was released to systems on the 10 March, and we are expecting further confirmation of funding week commencing 20 March.

11.6 The system plan for Spring 2023 is supported by a blend of community pharmacy, PCN and roving models, and provides sufficient capacity to meet current demand. Draft plans are in place for care homes and housebound and these are subject to confirmed funding. Discussions are underway with Cheshire and Wirral Partnership NHS Foundation Trust to build on and develop the living well bus roving offer, subject to funding, which was successful in the Autumn campaign. The system expects to receive national feedback from the 20 March which will allow for further refinement of the plan.

12. Decisions taken at the Executive Committee

12.1 Since the last Chief Executive report to the Board in February 2023, the following decisions have been made under the Executives' delegated authority at the Executive Committee. At each meeting of the Executive Team any conflicts of interest stated were noted and recorded within the minutes:

- **Area Prescribing Committee Prescribing Recommendations** – the Executive Team considered a paper outlining a number of NICE Technology Appraisals (TAs) and the prescribing recommendations against them. NICE TAs are based on clinical evidence showing how well a medicine or treatment works and the economic evidence showing how well the medicine or treatment works in relation to how much it costs the NHS. The NHS is legally obliged to fund and resource medicines and treatments recommended by NICE's TAs. The Executives approved the recommendations within.
- **Prometheus Contract Extension** – the Executive Team considered a paper regarding mental health patient conveyance and observational support in hospitals and the need to extend the contract of the current provider of services. The service provided by Prometheus is the provision of a 24/7 conveyance solution to support individuals who had been placed on a Mental Health section, and to provide appropriate and therapeutic observation of patients detained on a S136 within an Acute Hospital Place of Safety (PoS). This service helps to alleviate the pressures upon North West Ambulance Service (NWAS), Cheshire and Merseyside Police Forces and Local Authorities, and to improve the experience and care of our mental health (MH) patients. The Executives considered the recommendations within and approved the option to extend the service for the first quarter of 2023-24, noting that further work will be undertaken to look at the provision of the service going forward.

NHS Cheshire and Merseyside Integrated Care Board Meeting

Chief Executive's Report

Appendix One: Cheshire and Merseyside ICB Quarter 3 Assurance

Ref RB HH 2022-03-09

Richard Barker
North West Region
4th Floor
3 Piccadilly Place
Manchester
M1 3BN

richardbarker.nwrd@nhs.net

09 March 2023

Graham Urwin, Chief Executive Officer
Raj Jain, Chair
Cheshire and Merseyside Integrated Care Board

Raj.jain@cheshireandmerseyside.nhs.uk
Graham.Urwin@cheshireandmerseyside.nhs.uk

By email

Dear Graham and Raj,

2022-23 Cheshire & Merseyside Integrated Care Board Quarter 3 Assurance

I would like to thank you and your colleagues for attending the quarterly review meeting held on Wednesday 25th January 2023, and for providing a response to the key lines of enquiry in advance of the meeting. It was good to have full attendance from your senior team and the input from all colleagues was welcomed. As discussed, we will aim to hold every other meeting face to face, and so the next meeting will be in person.

The key areas from our discussions are outlined below.

Urgent Care

The Integrated Care Board highlighted the current challenging situation for operational clinical delivery, noting the high degree of occupancy in acute providers. There is still a high proportion of general and acute beds occupied by patients who no longer need to remain in hospital which appeared to reach a peak in early January. Mitigations are being put in place to cope with demand, and the Integrated Care Board is currently in the process of mobilising additional bed capacity across Cheshire and Merseyside. We noted that ambulance handover delays are low and working relationships are effective.

Utilisation of virtual wards has generally been high in Cheshire and Merseyside and we noted the trajectory to increase capacity from the 181 virtual beds to 595 by the end of Quarter 4. Clinical engagement and confidence in the model is critically important, and this is being supported with Clinical Advisory Groups, as well as experienced sites mentoring and tutoring new sites.

Elective and Cancer Recovery

The Integrated Care Board remains confident of meeting the March 2023 deadline for clearing 78 week waits. The risk that ongoing industrial action places on this target was noted.

There has been a significant increase in cancer demand, which is running at 130% of pre pandemic levels, and as much as 160% for the Lower GI pathway. It was noted that the conversion rate has remained constant, meaning the increase in demand is real. The link to diagnostics and the very real pressure that the increase puts on these services was discussed. The Cancer Alliance is leading the recovery work in relation to the cancer waiting list on behalf of the Integrated Care Board. It is critical that the Integrated Care Board provides sufficient oversight on delivery against all key cancer targets.

Finances and Planning

The Integrated Care Board expects to deliver the financial plan for the year. Once expected movements are reported these leaves £7 million to be found. Given the overall budget of the system is around £6 billion, the Integrated Care Board stated that it is confident of delivery, although there are still some risks associated with this. This position is not dependant on any additional revenue allocation from NHS England which would further improve the position if available. Thank you to you and your team for all of the hard work that has been undertaken to deliver this improved financial position.

The Integrated Care Board described the robust process that is in place for the 2023/24 planning round, including communication with the public and key stakeholders. You talked about some of the challenges moving from nine Clinical Commissioning Group plans to a single plan, and the background work that has been going on to harmonise policies to allow an equitable planning process across the Integrated Care Board.

We also noted the general support following the Carnal Farrar review and the crucial leadership role that the Integrated Care Board would take in working through to an action plan. We will be happy to support as required.

Workforce

It was noted that workforce will be a critical enabler for delivering the Integrated Care Board goals in 2023/24. The two provider collaboratives, along with primary care and social care, are developing system wide thinking for the workforce challenges. We look forward to you sharing these in future meetings.

The Integrated Care Board remains an outlier for sickness absence rates in comparison to other systems across the country, and there is a need to maintain a focus on improving this, which you acknowledged.

Summary

Overall, we are assured that you have a good understanding of the system's position in terms of data, finances, performance, and delivery. This provides a foundation on which you can build transformation, improvement and develop new ways of working. It is good to see how the financial position has improved over the last few weeks whilst improvements in the 78-week waiting list and the cancer waiting list must remain a priority. We want to encourage you as a Board to look to finish the year in as strong a position as possible.

We touched briefly on population health and health inequalities in the meeting but did not have the opportunity to discuss maternity, mental health, or some other priorities in primary care; as a result, we would like to return to these areas at our next meeting.

In terms of the System Oversight Framework (SOF), the Integrated Care Board is currently placed in segment 3. We committed to develop exit criteria with you going forward so it is

clear what steps the Integrated Care Board need to deliver to move to System Oversight Framework 2.

Thank you again for your ongoing work and effort in improving health care for the population of Cheshire and Mersey.

Yours sincerely

Richard Barker CBE

Regional Director (North West)

NHS Cheshire and Merseyside Integrated Care Board Meeting

Chief Executive's Report

Appendix Two: Running Cost Allowance: Efficiency requirements

To:
- ICB chief executives

cc.
- Regional:
  - directors
  - directors of finance
  - directors of system transformation

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

2 March 2023

Dear colleagues

ICB running cost allowances: efficiency requirements

Thank you for the extraordinary effort that you, your teams and your partner organisations in systems are making to keep services operating safely and effectively over the winter period.

Our letter of 24 January confirmed arrangements for delegation of commissioning responsibilities for pharmaceutical, general ophthalmic and dental (POD) services, including the impact of those transfers on ICB Running Cost Allowance (RCA) in 2023/24. We are now able to confirm the longer-term expectations on RCA.

The financial context for the NHS means that we need to review overall spending on management costs. In NHS England this has involved implementation of changes to significantly reduce the size of regional teams and national programmes, and to transfer staff and functions from regional teams to ICBs. We also need to ensure that ICBs are operating at their optimal size to deliver their strategic functions and to prioritise resources for front line care.

We know that many ICBs are already planning changes to their structures to reflect new statutory responsibilities following establishment in July 2022. We are therefore confirming changes to the RCA for the next three years to give maximum certainty.

In determining these changes we have listened to the views of ICB leaders and have set these in the context of the future funding settlement for the NHS. We believe that the level of reduction required is significant but deliverable. Setting the central requirement in terms of the overall RCA (which is based on population) for each ICB gives maximum flexibility to determine locally how to configure teams, what functions to outsource, and where to work across multiple geographies. There is no intention to drive changes to ICS footprints through this work but rather to ensure that collaboration is strengthened to enable efficiency requirements to be delivered.

Changes to RCA

Baseline Running Cost Allowances for ICBs have already been held flat in cash terms in 2023/24. This has been published through the annual operational planning guidance and the supporting publication of allocations for 2023/24 to 2024/25.

RCA will then be subject to a 30% real terms reduction per ICB by 2025/26, with at least 20% to be delivered in 2024/25. This provides time for ICBs to reorganise and gives some flexibility on funding change, with scope for ICBs to go further and faster where possible, enabling resources to be recycled into front line care. No increases to the RCA to allow for inflation in this period are anticipated. We are now updating the published future year RCA with three-year allocations for each ICB that reflect this 30% reduction. Adjustments for delegated POD functions will then be made separately.

At our regular joint meeting on 28 February we committed to setting up a session for ICB Chief Executives to work through the requirements and the resources available to support. We will aim to get this in the diary with you in the week commencing 6 March 2023. In addition, regional teams will work with ICBs to support implementation of these changes and will be able to provide access to benchmarking information and examples of good practice in organising or sharing functions as the work progresses. The development of provider collaboratives presents an important opportunity to streamline roles and action across systems and we expect that system partners will agree what resource should sit with provider collaboratives to support service transformation.

Thank you again for your all your ongoing efforts to deliver against the continuing operational challenges and for all the work with your partners on improving population health outcomes for people in England.

Yours faithfully

Mark Cubbon
Chief Delivery Officer
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

Julian Kelly
Chief Financial Officer
NHS England

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

30 March 2023

The Director of Nursing & Care's Report

Agenda Item No	**ICB/03/30/09**
Report author & contact details	Kerry Lloyd – Deputy Director of Nursing & Care
Report approved by (sponsoring Director)	Chris Douglas – Executive Director of Nursing & Care
Responsible Officer to take actions forward	Kerry Lloyd – Deputy Director of Nursing & Care

Cheshire and Merseyside ICB
Integrated Care Board Meeting

NHS Cheshire and Merseyside

Executive Summary	The purpose of the paper is to provide the Integrated Care Board (ICB) for Cheshire & Merseyside (C&M) with an overview of the current risks, issues and highlights that have an impact on quality and safety within the Cheshire and Merseyside ICS footprint. The report will feature updates that include: • Industrial Action • The Children & Young People's Beyond Conference • The Special Educational Needs & Disabilities (SEND) Workforce Consultation Update • Visits from national leaders • The All Age Continuing Care Review Update • The Serious Violence Duty.

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

Recommendation	**The Board is asked to:** • **Note** the content of the report and request additional information / assurance as appropriate.
Key issues	Preparation and planning have been ongoing since the first wave of industrial action (IA) in December 2022. The ICS established a governance framework that aligned to both national and regional architecture. Reducing the impact on the quality and safety during periods of IA continues to be a priority for ICS partners. Following on from last month's report and linked to the ICS success in working with Barnardo's and the Institute of Health Equity, led by Sir Michael Marmot, to shape the way ICSs create health and address health inequalities among children and young people, The Children and Young People's Beyond Board held is annual conference on the 7th Match 2023. The event was attended by over 120 partners from across NHS, social care, and the voluntary and independent sector. The ICB SEND workforce consultation period has now concluded with subsequent work to realign and support staff into new ways of working underway. The ICS will receive visits to two of its community providers in May 2023 in line with the retirement of the Deputy Chief Nursing Officer, Hilary Garratt. The Chief Nursing Officer for Adult Social Care, Deborah Sturdy, will also join a meeting of ICS social care nurses, at their regular round table event in April 2023. The work to review All Age Continuing Care Services in C&M continues with a first set of 'diagnostic' outcomes and associated

	proposals/recommendations being presented to the ICB Executive team in late March 2023. The ICB has new statutory duties in relation to Serious Violence as part of legislative changes that came into effect in December 2022. The report details the ongoing work to deliver on these responsibilities.
Key risks	• The ongoing impact of IA has the potential to impact upon the quality and safety of services. • The ICBs ability to deliver on its statutory duties in relation to Serious Violence Reduction.

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

Route to this meeting	Not Applicable
Management of Conflicts of Interest	No conflict of interest identified
Patient and Public Engagement	Not Applicable
Equality, Diversity, and Inclusion	The nature and content of the paper does not require an Equalities Health Impact assessment (EHIA) to be undertaken.
Health inequalities	Not Applicable
Next Steps	Reporting will continue via the established governance routes.
Appendices	None

Director of Nursing and Care Report

1. Executive Summary

1.1 The purpose of the paper is to provide the Integrated Care Board (ICB) for Cheshire & Merseyside (C&M) with an overview of the current risks and issues impacting on quality and safety within the Cheshire and Merseyside ICS footprint.

1.2 The report will feature updates that include:

- Industrial Action
- The Children & Young People's Beyond Conference
- The Special Educational Needs & Disabilities (SEND) Workforce Consultation Update
- Visits from national leaders
- The All Age Continuing Care Review Update
- The Serious Violence Duty.

2. Industrial Action

2.1 There have been ongoing periods of IA taking place throughout the month of March 2023, with the most significant taking place by The British Medical Association in relation to 'junior doctors' terms and conditions on the 13th – 15th March 2023, covering a 72-hour period. Other NHS Trade Union (TU) bodies stood down a series of IA dates following the announcement that Government and Trade Union would take place, these discussions have now concluded with the resultant pay offer now being put to TU members.

2.2 Preparation and planning have continued via the established clinical/workforce cell. The cell comprises Nursing, Human Resource and Medical senior leaders. The cell continues to meet on a regular basis, determined by intensity and frequency of IA and acts as a conduit for escalation and communication with ICS and regional partners.

2.3 The cell continues to gather insight and impact feedback from all affected organisations within C&M and has developed a tracker for oversight of any associated patient harm.

3. The Children & Young People's (CYP) Beyond Programme Annual Conference

3.1 The CYP Beyond Annual Conference took place on the 7th of March 2023. The event was attended by over 120 partners from across health, social care, independent and voluntary sector.

3.2 The event was opened by the ICB Chair, Raj Jain, who reaffirmed his commitment to ensure that the health and wellbeing of CYP in C&M is given parity with that of adults. He emphasised the moral obligation to do this, as well as outlining the economic argument in doing so.

3.3 The conference also heard from a range of speakers, including the Children's Commissioner (CC) for England, Dame Rachel De Souza. The CC outlined what had been heard back from CYP as to their views on how we can help to improve their lives and those of their families, emphasising the importance of listening to CYP, who often hold the answers in how we can improve their wellbeing.

3.4 The conference concluded with a plenary session supported by the Chief Executive of Alder Hey Hospital and SRO for the Beyond Board, Louise Shepherd; the Chief Executive of St Helens Local Authority and Chair of the Beyond Board, Kath O'Dwyer; and the Deputy Director of Nursing & Care for the ICS, Kerry Lloyd. The panel were asked a series of questions by CYP themselves as to the issues that mattered to them, a key theme of such questions involved encouraging and improving diversity and inclusion, as well as access to services.

4. The SEND Workforce Consultation Update

4.1 The ICS has now concluded its consultation on a revised workforce model for delivery of its statutory responsibilities in relation to those with SEND. This revised model for the workforce will support the evolution into an ICS based model and will enhance the senior leadership requirements to ensure that whilst the emphasis on place-based partnerships continue, the ICB can meet the requirements of being held to account as a statutory body, in and of itself.

5. The Serious Violence Duty

5.1 Following public consultation in July 2019, the Government announced that it would bring forward legislation introducing a new Serious Violence Duty on a range of specified authorities – the ICB has been identified as one of five specified authorities, that also include:

- Police
- Justice (including probation and youth offending teams)
- Fire & Rescue
- Local Authorities.

5.2 The Duty also requires that the specified authorities consult educational, prison and youth custody authorities for the area in the preparation of their strategy. This will ensure relevant services work together to share information and allow them to target their interventions, where possible through existing partnership structures, collaborate and plan to prevent and reduce serious violence within their local communities.

5.3 The Government also announced that it would amend the Crime and Disorder Act 1998 to ensure that serious violence is an explicit priority for Community Safety Partnerships and by making sure they have a strategy in place to explicitly tackle serious violence.

5.4 The Duty does not require the creation of new multi-agency structures. Local senior leaders may use existing local structures where possible to comply with the requirements of the Duty to work together to prevent and reduce serious violence in their local areas and, ultimately, to improve community safety and safeguarding.

5.5 By January 2024 the specified authorities must have produced a Joint Strategic Needs Assessment, response plans and a method for impact evaluation.

5.6 The ICBs Joint Forward plan will consider the duty and how it intends to use wider partnerships to reduce Serious Violence. The Office of the Police & Crime Commissioner is the convenor/fund holder for delivery of the duty, with ICBs as the focal point for all health-related aspects of Serious Violence.

5.7 It is suggested that the approach and its architecture should, where appropriate, align to Police Constabulary footprints and so the ICB will engage with both a Cheshire & Merseyside model. The model is further established on the Merseyside footprint, with a well-developed Violence Reduction Unit already in place. Cheshire will convene under the auspices of their Criminal Justice Board to further develop the requirements of the Duty.

5.8 The ICB is fully engaged in the work commissioned by the Home Office for specified authorities, in assessing its maturity and readiness for delivery of its responsibilities, in line with the legislative requirements and the ICB will be kept updated as plans further develop.

6. Recommendations

6.1 The Board is asked to:

- **Note** the content of the report and request additional information/assurance as appropriate.

7. Officer contact details for more information:

Kerry Lloyd – Deputy Director of Nursing & Care
Kerry.lloyd@cheshireandmerseyside.nhs.uk

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

30 March 2023

Cheshire and Merseyside System Finance Report Month 11

Agenda Item No	**ICB/03/30/10**
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 System Finance Report – Month 11

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. As at 28th February 2023 (Month 11), the ICS 'System' is reporting an aggregate deficit of £33.8m against a planned deficit of £47.8m resulting in an adverse year to date variance of £14m. This is an improvement of £22.9m on the position reported at month 10. Detailed work has been undertaken to review forecasts at individual organisation level and updated positions are reflected in this report. The system continues to forecast a position in line with its plan by year end.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X				
Recommendation	**The Committee is asked to:** • **Note** the contents of this report in respect of the Month 11 year to date and forecast outturn ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year.				
Key issues	The financial plan is expected to be delivered in year; however, delivery is heavily reliant on non-recurrent measures. Continued focus on delivery of recurrent efficiencies will be critical in supporting the financial sustainability of our system in the future.				
Key risks	Outlined within the main paper.				
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	
Route to this meeting	Papers previously discussed at ICB Finance, Investment and Resources Committee. Provider position will be presented to Cheshire and Merseyside Acute and Specialist Provider Collaborative in line with agreed reporting timetable				
Management of Conflicts of Interest	No specific issues raised				

Patient and Public Engagement	Financial performance at both place and provider level will be subject to local public communications and engagement arrangements.
Equality, Diversity and Inclusion	Efficiency Plans and Investment decisions will need to be subject to organisation level Equality Impact Assessments (EIA). This will be subject to internal audit review in line with locally agreed audit plans.
Health inequalities	Healthcare resource and investment decisions impact on health inequalities and so future place-based allocation decisions will be subject to EIA processes. Strong budget management and control is important to minimise areas of overspend which lead to an unplanned redistribution of resources.
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 1-5 gives details of the narrative in the main body of the report.

Cheshire and Merseyside System Finance Report – Month 11

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, 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.

Financial performance for the period ending 28th February 2023

- The system is reporting an aggregate deficit of £47.8m in the year to date against a planned deficit of £33.8m, resulting in an adverse year to date variance of £14m.
- This represents an improvement of £22.9m from the position last reported to the Board.
- Cost Improvement Plan performance has improved by £24.4m to £288m (full year plan is £330.9m).
- The system is no longer reporting an unmitigated financial risk and is currently reporting delivery of the planned system deficit position of £30.3m at the end of the year comprising a £43.0m deficit on the provider side, offset by a £12.7 surplus on combined CCG /ICB side

The year to date (YTD) position is set out in the table below and comprises a lower-than-plan YTD surplus position of £8.0m for CCGs/ICB (compared to a plan profile value of £16.4m) and a year-to-date deficit in the NHS providers of £71.6m (compared to plan profile of £50.4m).

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	18.0	11.2	(6.9)	12.7	(7.0)
NHS Providers Trusts	(50.0)	(51.8)	(59.0)	(7.2)	(42.9)	7.1
Total System	**(30.3)**	**(33.8)**	**(47.8)**	**(14.0)**	**(30.2)**	**0.1**

The system continues to forecast achievement of the annual planned deficit of £30.3m. The £7.1m favorable variance to plan for providers offsets the £7m unfavorable variance for the ICB and this is due to the transfer of a planning gap taken into the ICB position on behalf of providers who could not deliver their share of an improvement target, but which is now being delivered as by the provider sector overall.

M11 Performance – Capital

At end of February 2023, provider operational capital expenditure remains below year-to-date planned values by £21m but providers continue to report that the full allocations will be spent by the year end.

Cheshire and Merseyside ICB
Finance, Investment & Resource Committee

System Finance Report to 28th February 2023 (Month 11)

Background

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, and utilisation of available 'Capital' resources for the financial year.

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.

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.

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

Month 11 (February) Performance

ICB/CCG performance

5) For quarter 1, the CCGs allocations were adjusted to breakeven 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.

6) The ICB is currently reporting a year-to-date surplus of £8m compared to an original planned surplus of £16m resulting in an adverse variance to plan of £10.4m as per the table below:

	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	**(3,977.7)**			
ICB Net Expenditure				
Acute Services	2,088.0	2,085.4	2.6	0.1%
Mental Health Services	377.1	381.6	(4.4)	(1.2%)
Community Health Services	417.5	419.2	(1.7)	(0.4%)
Continuing Care Services	199.9	215.6	(15.7)	(7.8%)
Primary Care Services	408.7	419.0	(10.3)	(2.5%)
Other Commissioned Services	10.9	11.0	(0.1)	(0.7%)
Other Programme Services	44.2	40.4	3.8	8.6%
Reserves / Contingencies	1.5	(1.4)	2.9	198.0%
Delegated Primary Care Commissioning including:	371.1	365.4	5.8	1.6%
a) Primary Medical Services	*322.7*	*318.7*	*4.0*	*1.25%*
b) Pharmacy Services	*48.5*	*46.7*	*1.8*	*3.64%*
ICB Running Costs	34.0	34.7	(0.7)	(2.0%)
Total ICB Net Expenditure	**3,953.0**	**3,970.7**	**(17.8)**	**(0.4%)**
Adjustment for Reimbursable Items		**(4.2)**	**4.2**	
TOTAL ICB Surplus/(Deficit)	**24.7**	**11.2**	**(13.6)**	**(0.3%)**
**** NB - CCG Q1 Adjustment***	***(6.7)***	**-**	***6.7***	**0.5%**
Adjusted Surplus	***18.0***	***11.2***	***(6.9)***	***0.2%***

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

   a. Mental Health - increased volume and value of packages of care, including out of area placements and non-contracted activity. This risk is being managed collaboratively with Mental Health provider partners and expected to be mitigated non-recurrently in year though risk share and slippage on other relevant allocations.
   b. Primary Care Services - overspend on prescribing partially offset by underspends on GPIT and investments.
   c. Community Services – overspend relating to independent sector contracts and community equipment services offset by underspends following a detailed review of place budgets.
   d. Continuing care - overspend relating to increases to volume and price for continuing care packages and funded nursing care. This is an area of significant focus and review by each place team.
   e. Reserves – mitigations secured to offset accepted planning risks.
   f. Delegated Pharmacy – additional funding has now been received to offset the pressures previously seen in the year-to-date position. In addition, the underlying position an underspend as a result of a reduction in transition

fees for the remaining part of the year to cover the cost of the high uptake of the new advanced services.

g. Efficiency savings are built into the year-to-date position and reflects a favourable position of £0.2m but a significant proportion of this is non-recurrently delivered. This continues to be a key area of focus for place and corporate teams.

8) The ICB continues to forecast a surplus of £12.7m with the adverse variance to plan of £7m, offset by a favourable variance in the provider position. This is due to the transfer of a planning gap taken into the ICB position on behalf of providers who could not deliver their share of an improvement target, but which is now being delivered as by the provider sector overall.

NHS Provider Performance

9) The table below summarises the combined NHS provider position to the end of February 2023 reflecting a year-to-date cumulative deficit position of 59m compared to a year-to-date profile plan figure of £51.8m. Further detail is provided in Appendix 2.

	M11 YTD			M11 Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	ACTUAL £m	Variance £m
Alder Hey Children's NHS Foundation Trust	3.7	5.4	1.8	4.6	7.1	2.5
Bridgewater Community Healthcare NHS Foundation Trust	(0.0)	0.8	0.8	0.0	1.0	1.0
Cheshire and Wirral Partnership NHS Foundation Trust	2.6	2.8	0.3	2.9	3.2	0.3
Countess of Chester Hospital NHS Foundation Trust	(3.2)	(19.3)	(16.1)	(3.1)	(20.6)	(17.6)
East Cheshire NHS Trust	(2.6)	(1.7)	0.9	(2.6)	(1.2)	1.4
Liverpool Heart and Chest Hospital NHS Foundation Trust	2.1	3.7	1.6	2.3	4.1	1.8
Liverpool University Hospitals NHS Foundation Trust	(27.0)	(29.9)	(2.8)	(30.0)	(30.0)	0.0
Liverpool Women's NHS Foundation Trust	0.6	(3.9)	(4.5)	0.6	(1.6)	(2.2)
Mersey Care NHS Foundation Trust	5.1	12.8	7.7	5.7	16.9	11.2
Mid Cheshire Hospitals NHS Foundation Trust	(9.9)	(13.3)	(3.4)	(10.4)	(11.7)	(1.3)
Southport And Ormskirk Hospital NHS Trust	(14.8)	(14.4)	0.3	(14.2)	(13.8)	0.4
St Helens And Knowsley Teaching Hospitals NHS Trust	(6.2)	2.2	8.4	(4.9)	7.1	12.0
The Clatterbridge Cancer Centre NHS Foundation Trust	1.5	3.4	2.0	1.6	3.5	1.9
The Walton Centre NHS Foundation Trust	2.5	3.8	1.3	2.9	4.6	1.7
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(6.8)	(5.6)	1.2	(6.1)	(5.4)	0.7
Wirral Community Health and Care NHS Foundation Trust	0.6	0.7	0.0	0.7	0.7	0.1
Wirral University Teaching Hospital NHS Foundation Trust	(0.0)	(6.6)	(6.6)	0.0	(6.8)	(6.8)
Total Providers	**(51.8)**	**(59.0)**	**(7.2)**	**(50.0)**	**(42.9)**	**7.1**

10) 5 provider trusts as highlighted in section 13 continue to report an adverse year to date deficit position for months 1 to 11, resulting in an adverse position compared to plan of £33.4m.

11) Further analysis of the year-to-date position demonstrates that the adverse position is a result of higher than anticipated pay costs (£192.7m) and non-pay costs (£62.9m) offset set by favourable movements in Income (£234.5m) and non-operating items (£13.9m) 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	(5,136.9)	(5,371.4)	234.5	-4.6%	(5,606.7)	(5,856.5)	249.8	(4.5%)
Pay	3,331.7	3,524.4	(192.7)	(5.8%)	3,632.8	3,822.1	(189.3)	(5.2%)
Non Pay	1,768.0	1,830.9	(62.9)	(3.6%)	1,926.7	1,994.0	(67.3)	(3.5%)
Non Operating Items (exc gains on disposal)	89.0	75.1	13.9	15.7%	97.2	83.3	13.9	14.3%
Total Expenditure	5,188.7	5,430.4	(241.7)	(4.7%)	5,656.7	5,899.4	(242.7)	(4.3%)
C&M NHS Providers	**51.8**	**59.0**	**(7.2)**	**(13.8%)**	**50.0**	**42.9**	**7.1**	**14.2%**

12) Key pressures relate to underachievement on delivery of planned cost improvement programmes, rising inflation and operational pressures associated with continued provision of escalation bed capacity.

13) The following Trusts are currently reporting forecast adverse variances to plan. The ICB Executive team are meeting regularly 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.

- **Countess of Chester NHS Foundation Trust**
  Forecast £20.6m, £17.6m adverse variance to plan
  Key drivers are a high level of substantive vacancies resulting in high levels of agency and bank spend, increased energy costs, insourcing capacity and Waiting List Initiative (WLI) costs incurred to deliver elective recovery. CIP performance is behind plan, but being delivered non-recurrently, resulting in a future pressure.

- **Liverpool Women's NHS Foundation Trust**
  Forecast £1.6m deficit, £2.2m adverse variance to plan
  The variance is primarily driven by use of agency and premium rate staffing. This is due to high levels of sickness and national shortages of midwives and Obstetric consultants. They have raised a concern that they may struggle to meet their revised forecast and options for mitigating this position are being discussed across system partners.

- **Mid Cheshire NHS Foundation Trust (MCHFT)**
  Forecast £11.7m deficit, £1.3m adverse variance to plan
  The Trust is experiencing increased unplanned demand, resulting additional escalation beds and a newly opened discharge lounge. Premium costs are being incurred to staff these additional areas, driving the overspends reported against plan. CIP performance is behind plan and elective recovery is also behind pre-pandemic levels. They have raised a concern that they may struggle to meet their revised forecast and options for mitigating this position are being discussed across system partners.

- **Wirral University Teaching Hospitals NHS Foundation Trust**
  Forecast £6.8m deficit, £6.8m adverse variance to plan

The adverse variance to plan is as a result of 64 open escalation beds, use of corridor care in ED, increased energy costs and the Trust's underperformance in respect of recurrent CIP.

Provider Agency Costs

14) ICB Providers set a plan for agency spend of £113.3m, compared to actual spend in 2021/22 of £139.2m. The system is required to manage agency costs within budget and to demonstrate reduced reliance on agency staffing year on year.

15) Agency spend is being closely monitored with approval required from NHS England for all non-clinical agency above £50k. In Month 11, agency spend is £142.5m (£38.8m above plan), with all Trusts except for Southport and Ormskirk and Mid-Cheshire reporting adverse positions to plan. The forecast spend being reported by Trusts is £154m (£40.7m above plan) which equates to 4% of total pay.

Efficiencies

ICB Efficiencies

16) The ICB is currently reporting a £0.2m favourable variance to plan YTD mostly due to non-recurrent one-off savings. The ICB is currently forecasting to achieve the planned efficiencies of £68.8m.

17) The ICB has established a programme approach to identification, development and tracking of efficiencies and is a key area focus in respect of both this and future financial years and this has been a key area of focus in the recent place review meetings chaired by the ICB CEO.

Provider Efficiencies

18) Provider efficiency schemes are now £11m behind plan at month 11; efficiencies of £224.8m have been delivered to date compared to a plan of £235.9m. However, only £88.4m of this has been delivered recurrently (£136.5m 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.

System Risks & Mitigations

19) Following identification of further mitigations to support the system financial position the ICS is no longer reporting any unmitigated risk. The system is working closely together to manage any further risks as they arise to ensure delivery of the forecast position.

Provider Capital

20) 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.

21) At month 11, progress of the system's operational capital programme expenditure remains below year-to-date planned values by £29.6m. Detail by provider is set out in Appendix 5.

22) The system overall is forecasting to meet its capital expenditure plan for the year and within this all Trusts are forecasting achievement of plan. The variances reported against some Trusts are as a result of expected changes to allocations as detailed below:

a. LUHFT are forecasting an underspend of £22.2m, following the allocation of Additional PDC to support the New Hospital build and the release of the ICB reserve which was held by the Trust on behalf of the wider system.
b. Mersey Care are reporting a £1m underspend, which is related to spend at the Whalley Site, which is now being carried out by Lancashire Care on their behalf.
c. Southport and Ormskirk are reporting a £26m overspend, but this will be addressed when expected additional allocations are transacted in month 12.

Primary Care Capital

23) 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.

24) NHSE Primary Care commissioners have engaged with GP practices and premises grant requests totalling £1.074m in 22/23 with a further 23/24 impact of £1.289m 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.

25) Place digital leads identified and prioritised £4.1m for GP BAU IT. These programmes have been approved by NHSE regional team and the Primary Care Committee.

26) Slippage monies of £171k have been allocated to IT for Wireless LAN controllers and upgrades to Pharmacy IT infrastructure across the ICB.

27) In addition, the ICB has been allocated £935k related to small improvement grants and IT infrastructure for additional roles within primary care.

28) A £543k allocation for Falls has been distributed to Local Authorities.

29) An IFRS16 allowance of £550k has been allocated to the ICB for the Cunard Building Lease.

Strategic Capital

30) There are a large number of Strategic Capital schemes, administered by NHS England, the main ones being:

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

31) Business cases to bid for these funds have been submitted and most funds allocated for Mental Health, TIF, CDC, NHP and Diagnostics. Digital diagnostics and frontline digitisation are yet to be allocated.

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

33) 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.

Recommendations

The Board is asked to:

- Note the contents of this report in respect of the month 11 year to date financial position for both revenue and capital allocations within the 2022/23 financial year.

Officer contact details for more information

Claire Wilson
Executive Director of Finance
Cheshire and Merseyside ICB
Claire.Wilson@Cheshireandmerseyside.nhs.uk

Mark Bakewell
Deputy Director of Finance
Cheshire and Merseyside ICB
Mark.Bakewell@Cheshireandmerseyside.nhs.uk

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	(28,814)
NHS LIVERPOOL CCG	19,755
Total CCG Position	**(7,788)**
NHS LIVERPOOL CCG - as ICB Host	27.112
Total ICB Planned (Deficit/Surplus)	**19,669**

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 11 (28th February 2023)

	M11 YTD			M11 Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	ACTUAL £m	Variance £m
CCGs/ICB	**18.0**	**11.2**	**(6.9)**	**19.7**	**12.7**	**(7.0)**
Alder Hey Children's NHS Foundation Trust	3.7	5.4	1.8	4.6	7.1	2.5
Bridgewater Community Healthcare NHS Foundation Trust	(0.0)	0.8	0.8	0.0	1.0	1.0
Cheshire and Wirral Partnership NHS Foundation Trust	2.6	2.8	0.3	2.9	3.2	0.3
Countess of Chester Hospital NHS Foundation Trust	(3.2)	(19.3)	(16.1)	(3.1)	(20.6)	(17.6)
East Cheshire NHS Trust	(2.6)	(1.7)	0.9	(2.6)	(1.2)	1.4
Liverpool Heart and Chest Hospital NHS Foundation Trust	2.1	3.7	1.6	2.3	4.1	1.8
Liverpool University Hospitals NHS Foundation Trust	(27.0)	(29.9)	(2.8)	(30.0)	(30.0)	0.0
Liverpool Women's NHS Foundation Trust	0.6	(3.9)	(4.5)	0.6	(1.6)	(2.2)
Mersey Care NHS Foundation Trust	5.1	12.8	7.7	5.7	16.9	11.2
Mid Cheshire Hospitals NHS Foundation Trust	(9.9)	(13.3)	(3.4)	(10.4)	(11.7)	(1.3)
Southport And Ormskirk Hospital NHS Trust	(14.8)	(14.4)	0.3	(14.2)	(13.8)	0.4
St Helens And Knowsley Teaching Hospitals NHS Trust	(6.2)	2.2	8.4	(4.9)	7.1	12.0
The Clatterbridge Cancer Centre NHS Foundation Trust	1.5	3.4	2.0	1.6	3.5	1.9
The Walton Centre NHS Foundation Trust	2.5	3.8	1.3	2.9	4.6	1.7
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(6.8)	(5.6)	1.2	(6.1)	(5.4)	0.7
Wirral Community Health and Care NHS Foundation Trust	0.6	0.7	0.0	0.7	0.7	0.1
Wirral University Teaching Hospital NHS Foundation Trust	(0.0)	(6.6)	(6.6)	0.0	(6.8)	(6.8)
Total Providers	**(51.8)**	**(59.0)**	**(7.2)**	**(50.0)**	**(42.9)**	**7.1**
Total System	**(33.8)**	**(47.8)**	**(14.0)**	**(30.3)**	**(30.2)**	**0.1**

Note: brackets denote deficit/overspend.

Appendix 3

Agency spend: Current Performance and Forecast Outturn as at Month 11 (28th February 2023)

PROVIDER:	Month 11 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	(1.1)	(1.1)	0.0	(1.2)	(1.2)
Bridgewater Community Healthcare NHS Foundation Trust	(4.5)	(5.3)	(0.8)	(5.0)	(5.8)	(0.8)
Cheshire and Wirral Partnership NHS Foundation Trust	(2.8)	(7.2)	(4.4)	(3.1)	(7.8)	(4.7)
Countess of Chester Hospital NHS Foundation Trust	(7.7)	(16.6)	(8.9)	(8.4)	(18.1)	(9.7)
East Cheshire NHS Trust	(7.1)	(11.3)	(4.3)	(7.7)	(12.1)	(4.4)
Liverpool Heart and Chest Hospital NHS Foundation Trust	(0.6)	(1.1)	(0.5)	(0.7)	(1.1)	(0.4)
Liverpool University Hospitals NHS Foundation Trust	(11.2)	(14.7)	(3.5)	(12.2)	(15.6)	(3.4)
Liverpool Women's NHS Foundation Trust	(0.8)	(2.2)	(1.4)	(0.8)	(2.3)	(1.5)
Mersey Care NHS Foundation Trust	(16.3)	(19.0)	(2.7)	(17.7)	(20.6)	(2.9)
Mid Cheshire Hospitals NHS Foundation Trust	(19.2)	(19.1)	0.1	(21.0)	(20.4)	0.6
Southport And Ormskirk Hospital NHS Trust	(8.6)	(6.5)	2.2	(9.4)	(7.0)	2.4
St Helens And Knowsley Teaching Hospitals NHS Trust	(9.4)	(11.5)	(2.1)	(10.2)	(12.4)	(2.2)
The Clatterbridge Cancer Centre NHS Foundation Trust	0.0	(1.7)	(1.7)	0.0	(1.8)	(1.8)
The Walton Centre NHS Foundation Trust	0.0	(0.4)	(0.4)	0.0	(0.4)	(0.4)
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(9.3)	(13.4)	(4.1)	(10.2)	(14.8)	(4.5)
Wirral Community Health and Care NHS Foundation Trust	(1.6)	(2.3)	(0.8)	(1.7)	(2.6)	(0.9)
Wirral University Teaching Hospital NHS Foundation Trust	(4.5)	(9.0)	(4.5)	(5.0)	(9.9)	(4.9)
Total Providers	**(103.7)**	**(142.5)**	**(38.8)**	**(113.3)**	**(154.0)**	**(40.7)**
as a proportion of Total Pay	-4.28%	-5.55%		3.12%	4.03%	

Appendix 4

System Efficiencies: Current Performance and Forecast Outturn as at Month 11 (28th February 2023)

	M11 YTD			M11 Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	ACTUAL £m	VARIANCE £m
CCGs/ICB	63.0	63.2	0.2	68.8	68.8	0.0
	63.0	**63.2**	**0.2**	**68.8**	**68.8**	**0.0**
Providers:						
Alder Hey Children's NHS Foundation Trust	13.1	13.5	0.4	14.5	14.5	0.0
Bridgewater Community Healthcare NHS Foundation Trust	3.8	3.8	0.0	4.2	4.2	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	7.6	7.5	(0.1)	8.3	8.3	0.0
Countess of Chester Hospital NHS Foundation Trust	11.9	13.5	1.6	13.4	14.8	1.4
East Cheshire NHS Trust	4.9	4.9	(0.0)	5.5	5.5	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	4.5	5.3	0.8	4.9	6.4	1.5
Liverpool University Hospitals NHS Foundation Trust	68.1	61.6	(6.5)	75.0	75.0	0.0
Liverpool Women's NHS Foundation Trust	5.1	4.6	(0.5)	5.6	5.8	0.2
Mersey Care NHS Foundation Trust	20.9	20.9	0.0	22.8	22.8	0.0
Mid Cheshire Hospitals NHS Foundation Trust	15.4	14.9	(0.5)	16.8	16.3	(0.5)
Southport And Ormskirk Hospital NHS Trust	9.2	9.2	0.0	10.8	10.8	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	24.2	24.2	0.0	28.1	28.1	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	6.2	6.2	0.0	6.8	6.8	(0.0)
The Walton Centre NHS Foundation Trust	4.5	4.5	0.0	4.9	4.9	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	13.8	11.0	(2.8)	15.7	14.6	(1.1)
Wirral Community Health and Care NHS Foundation Trust	3.8	3.3	(0.4)	4.1	4.1	0.0
Wirral University Teaching Hospital NHS Foundation Trust	19.1	16.1	(3.0)	20.8	20.8	(0.0)
Total Providers	**235.9**	**224.8**	**(11.0)**	**262.2**	**263.7**	**1.5**
Total System	**298.9**	**288.0**	**(10.8)**	**330.9**	**332.4**	**1.5**

Recurrent/Non-recurrent split of Provider CIP delivery

PROVIDERS	Recurrent				Non Recurrent				TOTAL			
	M11 YTD Actual £m	M11 YTD Variance £m	Forecast ACTUAL £m	Forecast VARIANCE £m	M11 YTD Actual £m	M11 YTD Variance £m	Forecast ACTUAL £m	Forecast VARIANCE £m	M11 YTD Actual £m	M11 YTD Variance £m	Forecast ACTUAL £m	Forecast VARIANCE £m
Alder Hey Children's NHS Foundation Trust	6.0	(2.7)	7.0	(2.7)	7.5	3.1	7.5	2.7	13.5	0.4	14.5	0.0
Bridgewater Community Healthcare NHS Foundation Trust	1.3	(0.4)	1.4	(0.5)	2.5	0.4	2.8	0.5	3.8	0.0	4.2	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	2.7	0.3	2.9	0.2	4.8	(0.4)	5.4	(0.2)	7.5	(0.1)	8.3	0.0
Countess of Chester Hospital NHS Foundation Trust	5.0	0.2	5.6	0.1	8.5	1.4	9.2	1.3	13.5	1.6	14.8	1.4
East Cheshire NHS Trust	1.8	(1.4)	2.0	(1.5)	3.1	1.3	3.5	1.5	4.9	(0.0)	5.5	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	2.9	(0.6)	3.8	(0.0)	2.3	1.4	2.5	1.5	5.3	0.8	6.4	1.5
Liverpool University Hospitals NHS Foundation Trust	9.7	(18.0)	13.0	(19.0)	51.9	11.5	62.0	19.0	61.6	(6.5)	75.0	0.0
Liverpool Women's NHS Foundation Trust	1.6	(2.2)	1.8	(2.4)	3.0	1.7	4.0	2.6	4.6	(0.5)	5.8	0.2
Mersey Care NHS Foundation Trust	14.0	(0.2)	15.3	(0.2)	6.8	0.2	7.5	0.2	20.9	0.0	22.8	0.0
Mid Cheshire Hospitals NHS Foundation Trust	5.2	(1.2)	6.1	(1.0)	9.7	0.7	10.2	0.6	14.9	(0.5)	16.3	(0.5)
Southport And Ormskirk Hospital NHS Trust	6.6	(2.5)	7.8	(3.0)	2.5	2.5	3.0	3.0	9.2	0.0	10.8	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	18.2	(2.0)	22.1	0.0	6.0	2.0	6.0	0.0	24.2	0.0	28.1	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	2.5	(1.6)	3.0	(1.5)	3.8	1.6	3.8	1.5	6.2	0.0	6.8	0.0
The Walton Centre NHS Foundation Trust	2.9	(0.8)	3.2	(0.9)	1.7	0.8	1.7	0.9	4.5	0.0	4.9	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	1.5	(4.1)	1.6	(4.9)	9.4	1.3	13.0	3.8	11.0	(2.8)	14.6	(1.1)
Wirral Community Health and Care NHS Foundation Trust	1.7	(0.8)	2.3	(0.3)	1.6	0.3	1.8	0.3	3.3	(0.4)	4.1	0.0
Wirral University Teaching Hospital NHS Foundation Trust	4.7	(8.0)	5.8	(8.1)	11.4	5.0	15.1	8.1	16.1	(3.0)	20.8	(0.0)
Total Providers	**88.4**	**(46.0)**	**104.7**	**(45.8)**	**136.5**	**34.9**	**159.0**	**47.3**	**224.8**	**(11.0)**	**263.7**	**1.5**

Appendix 5

Provider Capital: Current Performance and Forecast Outturn as at Month 11 (28th February 2023)

Excluding IFRS16 Impact

PROVIDER:	M11 YTD			M11 FORECAST		
	PLAN	ACTUAL	VARIANCE	PLAN	ACTUAL	VARIANCE
	£m	£m	£m	£m	£m	£m
Alder Hey Children's NHS Foundation Trust	7.1	7.2	(0.1)	8.9	8.9	0.0
Bridgewater Community Healthcare NHS Foundation Trust	2.0	0.6	1.4	2.1	1.7	(0.4)
Cheshire and Wirral Partnership NHS Foundation Trust	2.5	2.1	0.4	2.6	2.5	(0.1)
Countess of Chester Hospital NHS Foundation Trust	14.9	12.8	2.2	19.9	19.6	(0.2)
East Cheshire NHS Trust	5.6	3.8	1.8	6.1	6.4	0.3
Liverpool Heart and Chest Hospital NHS Foundation Trust	10.0	8.5	1.5	11.3	11.3	0.0
Liverpool University Hospitals NHS Foundation Trust	56.9	35.0	21.9	62.6	40.3	(22.2)
Liverpool Women's NHS Foundation Trust	8.7	6.6	2.1	8.8	8.8	0.0
Mersey Care NHS Foundation Trust	9.7	5.3	4.4	11.1	10.1	(1.0)
Mid Cheshire Hospitals NHS Foundation Trust	26.1	29.9	(3.8)	38.6	38.6	(0.0)
Southport And Ormskirk Hospital NHS Trust	10.2	24.4	(14.3)	11.3	37.3	26.0
St Helens And Knowsley Teaching Hospitals NHS Trust	4.0	2.6	1.5	4.5	4.5	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	6.4	3.7	2.7	7.0	7.2	0.2
The Walton Centre NHS Foundation Trust	5.3	2.1	3.1	5.7	5.7	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	9.7	7.1	2.6	12.5	12.5	0.0
Wirral Community Health and Care NHS Foundation Trust	8.8	7.7	1.0	9.4	9.4	(0.0)
Wirral University Teaching Hospital NHS Foundation Trust	10.8	9.7	1.1	11.9	11.9	(0.0)
Total Charge against System Operational Capital Plan	**198.7**	**169.1**	**29.6**	**234.3**	**236.9**	**2.6**
System Operational Capital Allocation				**220.9**	**236.9**	**(16.0)**

(based on formal reporting to NHSEI)

Note: brackets denote deficit/overspend

Appendix 5

Provider Cash Month 11 (28th February 2023)

PROVIDER:	MONTH 11 ACTUAL £m	31/03/2022 BALANCE £m	% INCREASE/ DECREASE TO MONTH 12 £m
Alder Hey Children's NHS Foundation Trust	86.1	91.5	(5.8%)
Bridgewater Community Healthcare NHS Foundation Trust	27.4	26.2	4.6%
Cheshire and Wirral Partnership NHS Foundation Trust	36.7	41.1	(10.7%)
Countess of Chester Hospital NHS Foundation Trust	18.5	40.9	(54.8%)
East Cheshire NHS Trust	31.6	37.3	(15.1%)
Liverpool Heart and Chest Hospital NHS Foundation Trust	47.2	42.7	10.4%
Liverpool University Hospitals NHS Foundation Trust	125.8	211.4	(40.5%)
Liverpool Women's NHS Foundation Trust	10.8	11.2	(3.6%)
Mersey Care NHS Foundation Trust	99.7	84.2	18.4%
Mid Cheshire Hospitals NHS Foundation Trust	16.7	26.7	(37.7%)
Southport And Ormskirk Hospital NHS Trust	11.1	18.5	(40.1%)
St Helens And Knowsley Teaching Hospitals NHS Trust	63.8	54.2	17.7%
The Clatterbridge Cancer Centre NHS Foundation Trust	87.7	80.7	8.6%
The Walton Centre NHS Foundation Trust	46.8	40.7	14.8%
Warrington and Halton Teaching Hospitals NHS Foundation Trust	33.9	44.7	(24.1%)
Wirral Community Health and Care NHS Foundation Trust	16.3	23.8	(31.7%)
Wirral University Teaching Hospital NHS Foundation Trust	20.7	36.4	(43.3%)
Total Providers	**780.6**	**912.1**	**(14.4%)**

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

30 March 2023

Quality & Performance Report – Board Summary

Agenda Item No	**ICB/03/30/11**
Report author & contact details	Andy Thomas (contact details in body of report)
Report approved by (sponsoring Director)	Anthony Middleton, Director of Performance and Planning
Responsible Officer to take actions forward	Andy Thomas, Associate Director of Planning

Quality & Performance Report
Board Summary

Executive Summary	The attached presentation 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.				
Key issues	• The urgent and emergency care system continues to experience significant and sometimes severe pressure across the whole of NHS Cheshire & Merseyside. • Significant backlogs for both elective and cancer care.				
Key risks	• Impact on ambulance response times, ambulance handover times, long waits in ED resulting in poor patient outcomes and poor patient experience. • Long waits for cancer and elective treatment resulting in poor outcomes.				
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				
Equality, Diversity and Inclusion	n/a				
Health inequalities	n/a				
Next Steps	n/a- regular report				
Appendices	Summary Report				

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). The majority of Trusts across C&M have been consistently reporting at OPEL 3 for an extended period during 2022 and into 2023. OPEL 3 is defined as 'the local health and social care system is experiencing major pressures compromising patient flow'.

1.3 As winter pressures continued to build over the course of December and into January a total of six of Trusts across C&M declared the highest level of escalation, OPEL 4 on one or more occasions, with 15 separate declarations over this period.

1.4 Since mid-January most Trusts have continued to escalate predominantly at OPEL 3 or better, however increased pressure has been observed since late February and into March, with some further OPEL 4 declarations. Overall pressures are still consistent with a challenging winter situation as expected.

1.5 Category 2 ambulance call response times, which should be responded to within 18 minutes and includes serious presenting conditions including patients who may have had a stroke or are experiencing chest pain, deteriorated significantly in late 2022, reaching an average for December 2022 of 1 hour 53 minutes and 3 seconds. Performance was particularly challenged in the early part of January also, but since this time there has been a significant improvement in response times, with the February 2023 mean response time at 28 minutes.

1.6 Ambulance handover delays, both those between 30 and 60 minutes, and delays over 60 minutes rose significantly in December, and this continued into the first weeks of January. Subsequently, in line with the easing of pressure described above, handover delays reduced considerably over the remainder of January.

1.7 The delays in ambulance handovers at hospitals relate to overcrowding in emergency departments caused by a combination of high demand and insufficient bed capacity available within our hospitals to admit all those patients requiring a hospital bed.

1.8 These delays often lead to patients having to wait for a bed in the emergency department or on an assessment unit, as can be seen from high number of patients experiencing a delay of over 12 hours from the point of a decision to admit, which although improved from the peak in December, remains exceptionally high at 3,761.

1.9 The impact on ED of delays from decision to admit is crowding in department and in waiting areas and corridor care. In terms of corridor care, which is an indication of severe pressure in the urgent and emergency care pathway, whilst this is improved from the levels seen in December and early January, most acute Trusts with the exception of Alder Hey and specialist trusts, have had to care for patients on corridors during times of peak demand in order to try to release ambulance crews as rapidly as possible.

1.10 The majority of C&M acute Trusts with an Emergency Department continue to report bed occupancy in excess of 95%, typically in a range from 97%-100%, despite the opening of additional escalation beds. The lower occupancy levels reported in the performance tables reflect the inclusion of specialist Trusts.

1.11 Bed occupancy in adult mental health is also very high, running at or close to 100%, impacting on the ability of mental health trusts to accommodate patients who attend an acute emergency department and require admission. As is the case with acute care, a significant number of adult mental health beds are occupied by patients who are ready for discharge but are awaiting supported accommodation, care homes, nursing placements and further non-acute input.

1.12 Within acute Trusts, there continues to be a significant number of patients no longer meeting the criteria to reside in hospital. In January and February this has remained virtually unchanged at 22.3% in February, down 0.1% on January. Within this there is significant variation across Trusts. The number of patients not meeting the criteria to reside within Trusts across Cheshire and Merseyside typically remains in excess of 1,000 on any given day with the majority awaiting packages of support to enable their discharge home.

1.13 Long length of stay is also a significant factor in the persistently high levels of bed occupancy. Patients with a length of stay over 21 days account for nearly 28% of occupied bed.

1.14 In conjunction with the continued underlying level of COVID-19 occupancy, which increased in February and into March standing at approximately 7% of admitted patients as at mid-March, this in turn means that there are often insufficient beds to admit patients from the Emergency Department or direct admissions requiring beds.

1.15 Winter plans included additional national funding to open an additional 206 beds over the course of the winter, which were all opened ahead of schedule by the end of January 2023.

1.16 The ICB opened its System Control Centre (SCC) on 01 December in line with national guidance. The SCC operates daily, gathering intelligence and where possible brokering mutual aid across the system.

1.17 This has been augmented by a dedicated EPRR response to industrial action since December 2022, with an Incident Coordination Centre stood up alongside the SCC on industrial action days. Whilst some of the industrial action in December and January saw reductions in demand on the days of action, for the latest industrial action days most trusts saw an increase in attendances to their emergency departments with significant increases for St Helens and Knowsley and Southport & Ormskirk hospitals in particular who experienced the highest numbers of attendances since December 2022.

1.18 Place Directors are working closely with their respective Local Authorities to facilitate discharge. Given the extraordinary level of pressure this winter, this response has included a focus on increasing and then maintaining the run rate of hospital discharges every day and collectively increasing risk-based decisions about who can go home earlier with a lower package of care than might previously have been assessed.

1.19 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.

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. Patients waiting for long periods of time may experience a deterioration in their condition and may subsequently require more interventions. We are working hard to clear the longest waiting patients to reduce this risk.

2.3. The current priority is eliminating waits in excess of 78 weeks by the end of March 2023.

2.4. Whilst the total waiting list for elective care has been growing, Trusts have been making significant progress in reducing the numbers of patients waiting 78 weeks or longer. The most recent unpublished data indicates that with 3 weeks to go to the end of March deadline there were 1,557 patients waiting over 78 weeks to be cleared. In the past 26 weeks Trusts have cleared 36,169 patients in this cohort.

2.5. We continue to work with trusts through the mutual aid hub and meet weekly with each trust to review their waiting list and support with accessing all possible capacity (including diagnostics, independent sector, and sourcing capacity out of area).

2.6. The providers with the highest number of patients to clear are LUHFT (402) and St Helens & Knowsley (352). The C&M PTL and mutual aid team are working intensively with these trusts to ensure we offer all possible support.

2.7. Whilst very significant progress towards this ambition has been made, at the time of writing it was recognised that due to a range of factors there is a heightened risk that not all 78 week wait patients will have been cleared by the end of March and that a number of breaches may still occur. A real time update will be provided at Board.

2.8. The theatre utilisation programme continues, and each month an “opportunity pack” is produced to show where there are specialty-level opportunities to increase throughput.

2.9. A coaching programme will commence in April to offer intensive training to trust teams leading theatre improvement programmes to cascade the skills and knowledge around theatre improvement. Our mutual aid hub team have facilitated mutual aid for over 3,500 patients in order to expedite their treatment and / or appointments and support trusts with the long wait challenges.

2.10. The clinical pathways team have held workshops for ENT and Dermatology over the last month to work through current challenges and opportunities for the specialties and develop plans for sustainable service planning.

2.11. In terms of the total waiting list for elective care, this had been growing consistently, with referral to treatment clock starts consistently exceeding clock stops. However, over the last few months the gap between clock starts and stops has reduced, and growth has gradually plateaued, and in December 2022 showed a small reduction. This is also due in part to ongoing validation of waiting lists and reflects the work described above to clear long waits.

2.12. Elective recovery to pre pandemic levels is measured in terms of value-weighted elective activity compared to for access to the Elective Recovery Fund. By this measure, the latest published data for the month ending 31 December 2022, taken from Trust activity submitted via SUS puts Cheshire & Merseyside at 94.5% of 2019/20 spend value compared to 92.8% for the North West, and 95.4% for England.

2.13. For diagnostics the national waiting target remains at <1% waiting over 6 weeks for a diagnostic test and zero 13+ week waiters with recovery targets of 95% of patients receiving a test by March 2025.

2.14. A national activity target has been set at 120% of pre-pandemic levels, specifically 2019/20 activity baseline across a range of seven common diagnostic modalities.

2.15. Cheshire & Merseyside is at 140.9% as at December, compared to 102.5% for the NW region.

2.16. Due to winter pressures and industrial action, December saw diagnostic activity drop and waiting times increase for the first month in 2022/23. 75.7% of patients had been waiting 6 weeks or less in December, compared to 80% in November.

2.17. As a result of additional Community Diagnostic Centres opening and further work to reduce long waiting patients across all trusts, The C&M Diagnostic Programme is projecting a return to higher activity levels and lower waiting times in Jan/Feb 2023 data.

3. Cancer

3.1. A sharp and sustained rise in urgent suspected cancer referrals, 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 since 2019.

3.2. Urgent suspected cancer GP referrals continue on an upward trend. Year to date referrals are 129% of pre-pandemic baseline. December 2022 (latest published month) was 123.3% compared with 113.6% nationally.

3.3. Between February 2022 and January 2023 the overall number of patients seen on a 2 week referral pathway was 156,037 compared to 141,862 in the previous 12 month period. More patients than ever are therefore being seen and are being seen within target time. However, performance against the 14-day standard still remains below target at 76.9%, higher than the North West average of 75.1%, but short of the England performance of 80.3%.

3.4. 28-day faster diagnosis performance remains challenged due to high referral volumes and operational pressures. Performance was 65.6% in December 2022 but dropped to 61.8% in January 2023.

3.5. Lower GI cancer pathways are under significant pressure in most providers as a combined result of increased referrals and diagnostic capacity constraints. LGI referrals in 2022/23 YTD are 160% of pre-pandemic (2019) levels.

3.6. Similarly, a negative impact on performance was noted in January, with 31-day cancer performance dropping to 90.8%. The England performance also dropped significantly from 92.7% to 88.5%. 62-day cancer performance saw a similar deterioration, dropping to 55.6% for Cheshire & Merseyside and 54.4% for England.

3.7. The number of patients waiting more than 62 days for a diagnosis or treatment (aka the over 62-day backlog) remains a concern. Nearly half the backlog is made up of patients on suspected LGI cancer pathways. The over 62-day cancer backlog stood at 2,068 as at 29 January 2023.

3.8. High referral levels have resulted in more cancer patients being diagnosed and treated than in any previous year. Data suggest that the proportion of patients diagnosed with early-stage cancers has increased, which is positive.

3.9. However, although a greater number of patients have been seen and treated within target times, high volumes have meant that significant numbers of patients have experienced delays. The impact will continue to be monitored through patient experience surveys and clinical harm reviews.

3.10. Cancer services are busier than ever, seeing and treating more patients each month than ever before. Conversion rates have not significantly changed, and the number of new cancers diagnosed has increased. This suggests that, in most cases, the increase in demand (i.e. GP cancer referrals) is genuine and appropriate.

3.11. 3,000 additional cancer first appointments are being provided each month compared with 2019 to manage increased demand.

3.12. The Cancer Alliance is supporting improved efficiency and productivity with funding and project resources through the faster diagnosis programme.

3.13. Lower GI pathways continue to be the focus of targeted support, primarily through the Alliance's faecal immunochemical testing (FIT) programme and the Endoscopy Network's improvement programme.

3.14. Capital investments, training & education (in both primary and secondary care) and a pipeline of innovation are all building resilience and supporting recovery. However, significant further investment in the cancer workforce is required.

3.15. The key targets highlighted in the 2023/24 operational planning guidance, namely the 28-day faster diagnosis standard and the reduction of the over 62-day backlog, are both anticipated to be achieved by the end of Q4 2023/24 in line in the national expectation.

4. Mental Health & Learning Disabilities

4.1. Data quality issues continue to have an adverse impact on nationally published data and some indicators cannot be considered an accurate reflection of activity.

4.2. Data Quality Improvement Plans will be agreed with NHS providers and actions progressed to ensure non-NHS and primary care MH data are flowing via national data sets.

4.3. Out of area placement bed days had been steadily reducing over a 3 month consecutive period. However, numbers have increased for Cheshire and Wirral because of an increase in the number of delayed discharges and continued levels of high demand.

4.4. Opportunities to access additional discharge funding being explored via place.

4.5. Further North West level meetings have taken place to progress the development of an Escalation Framework for adult MH to reduce the number of delayed discharges and improve acute care flow. A clinical prioritisation assessment is undertaken for all patients waiting for a MH bed.

4.6. Early intervention in psychosis services recovered delivery of 60% of people being treated within 2 weeks during the reporting period following recruitment to vacant posts.

4.7. Targeted actions are being undertaken as part of Community MH transformation to increase access to Individual Placement Support (IPS) services to help people with severe mental illness find and sustain employment.

4.8. In relation to reliance on specialist inpatient care for children with a learning disability and/or autism, in February 2023 there were 5 children and young people (CYP) with LD/A in a tier 4 bed against a Q4 target of 9.

4.9. Low numbers of admissions and shorter length of Stay will have a positive impact on a CYP's care and treatment.

4.10. The development of the Dynamic Support Register work has allowed Place leads to identify children and young people at risk of admission much sooner to ensure admissions are appropriate and hospital admission avoidance is achieved where it is deemed appropriate.

4.11. Similarly, the escalation process is being used to review and reduce length of stay where it is considered that a placement is no longer appropriate.

4.12. In relation to adult inpatients with a learning disability and/or autism per million head of population, in February 2023 adult inpatients stood at 47 for Place commissioners, 49 for adult specialised commissioning. Target for Q4 22/23 is 70.

4.13. Quality and performance challenges in this area include ongoing pressure on ATU bed capacity, in part due to delayed discharges. Delays in identifying suitable housing and fitting the essential adaptations contribute to delayed discharges, as do workforce issues in terms of recruiting teams to support patients in the community. These delays in turn can affect the health and well-being of the patient and have a wider impact on families.

4.14. Transforming Care staff are helping with the back log of Care and Treatment reviews (CTR's) within Specialised Commissioning where a number of people have also been identified as delayed discharges

4.15. Weekly Sit reps have been in place since October 2022 to update on progress of delayed discharges, along with fortnightly desktop reviews with Place commissioners and LPC case managers and individual escalation calls where required.

5. Primary Care

5.1. There are 355 GP Practices across Cheshire and Merseyside, looking after a population of 2.7 million people with the GP Practices grouped into 55 Primary Care Networks to deliver certain functions under the relevant national contracts.

5.2. GP practices were asked to focus on 'recovery and restoration' of general practice services, returning to pre-pandemic levels and scope of delivery as quickly as possible during 2022-23

5.3. In relation to access, appointment activity remains higher than the same pre-pandemic period.

5.4. The mix of appointments across Cheshire & Merseyside however shows that face to face appointments, are overall slightly lower than pre pandemic but there has been a relative increase in telephone appointments.

5.5. Appointment data is reported and overseen at the System Primary Care Committee (bimonthly) where assurance is given on actions to support this at place and corporate level.

5.6. Dental access remains challenging – access is low across Cheshire & Merseyside, with an ongoing impact on urgent dental care as a result. A Dental Improvement Plan will be drafted during Q1 of 23/24 when the ICB takes commissioning responsibility.

6. Recommendations

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

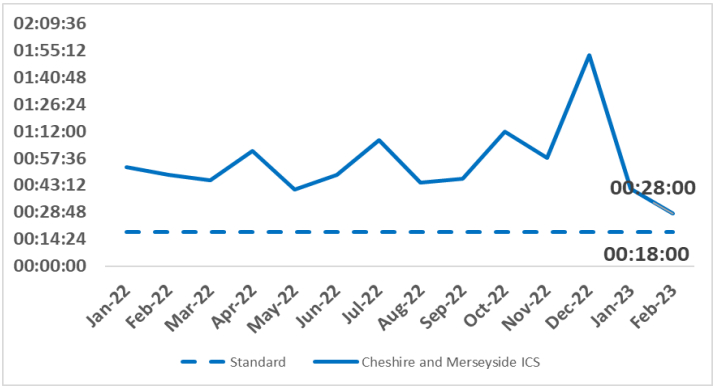
NHS
Cheshire and Merseyside

Performance Report

NHS
Cheshire and Merseyside

Section I: Urgent Care

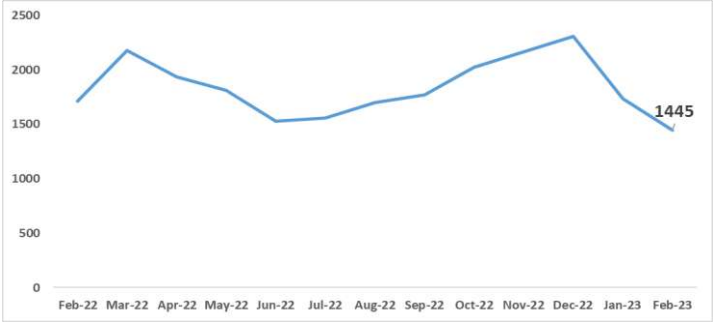
Ambulance Response times – Cat 2



Organisation	Dec-22	Jan-23	Feb-23
Cheshire & Merseyside	01:53:03	00:41:20	00:28:00
North West	01:12:11	00:29:17	00:22:36
England	01:18:57	00:32:06	00:32:20

North West & England figures published nationally, C&M figures from NWAS portal

Ambulance Arrival to handover 30 to 60 mins

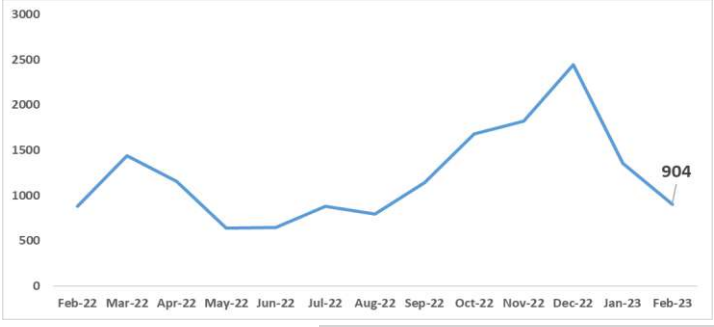


Organisation	Dec-22	Jan-23	Feb-23
Cheshire & Merseyside	2304	1734	1445**
North West	6623	5282	4333
England	*	23919*	44734

*NW & England data published only from 16th January

** Locally available data only available until 6th February

Ambulance Arrival to handover >60 mins



Organisation	Dec-22	Jan-23	Feb-23
Cheshire & Merseyside	2442	1356	904**
North West	6772	3494	2124
England	*	12380*	29739

*NW & England data published only from 16th January

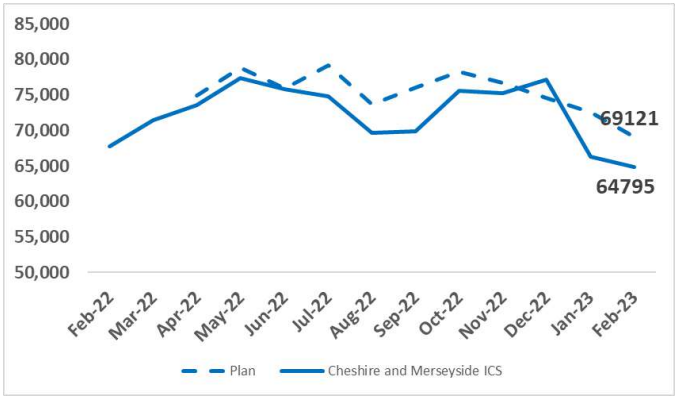
** Locally available data only available until 6th February

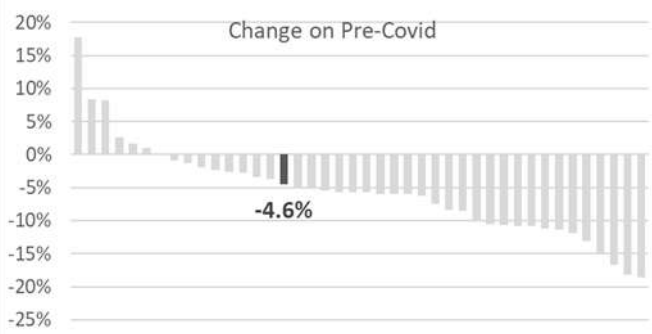
	Feb-23		
	Total arrivals	>60 min arrival to handover	% attends over 60 mins
Liverpool University Hospitals (Aintree)	1966	236	12%
Alder Hey	274	0	0%
Wirral University Teaching Hospital	1452	188	13%
Countess of Chester	997	147	15%
Mid Cheshire Hospitals	1479	4	0%
East Cheshire Hospitals	730	19	3%
Liverpool University Hospitals (Royal)	1727	104	6%
Southport & Ormskirk Hospital	1022	49	5%
Warrington & Halton Hospital	1369	112	8%
St Helens & Knowsley Hospital	1846	45	2%

NHS
Cheshire and Merseyside

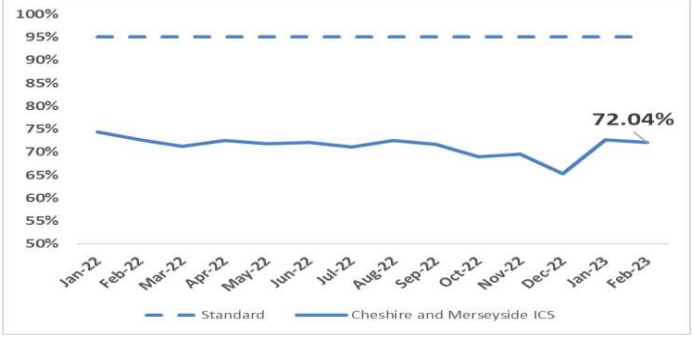
Section I: Urgent Care

A&E Attendances (Type 1)



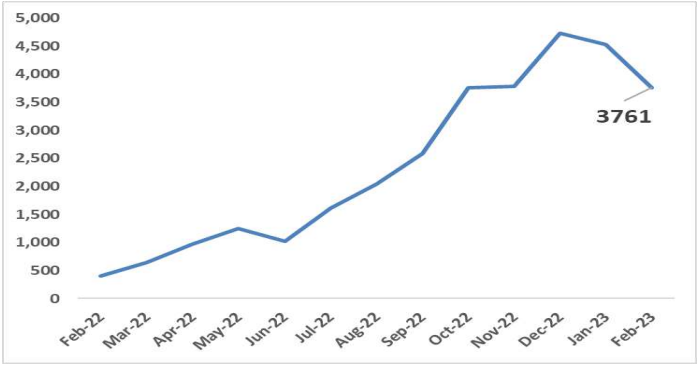


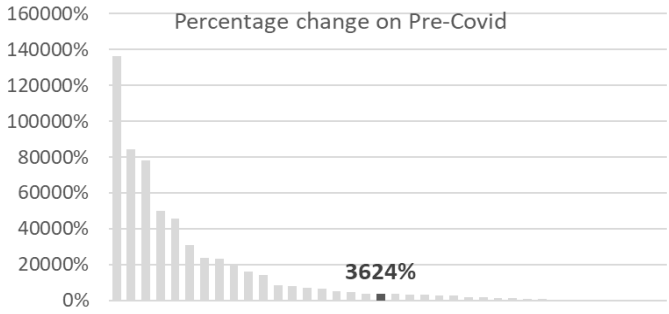
A&E 4 Hour Standard



Organisation	Dec-22	Jan-23	Feb-23
Cheshire & Merseyside	65.2%	72.7%	72.0%
North West	62.6%	69.9%	69.8%
England	68.2%	74.8%	74.0%

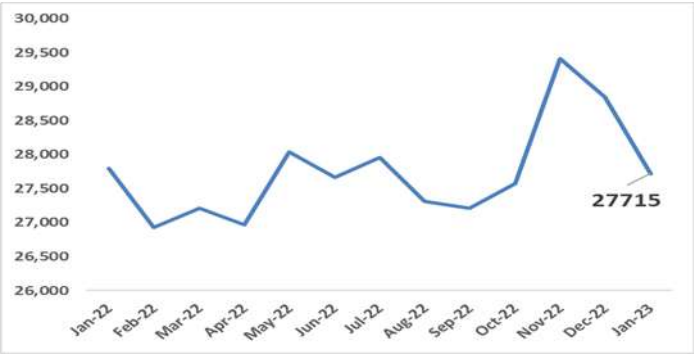
A&E 12 hour delays from decision to admit

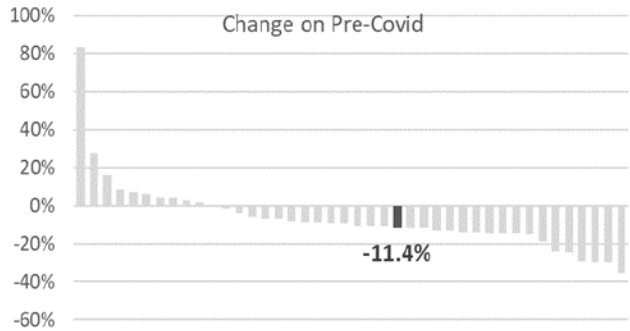




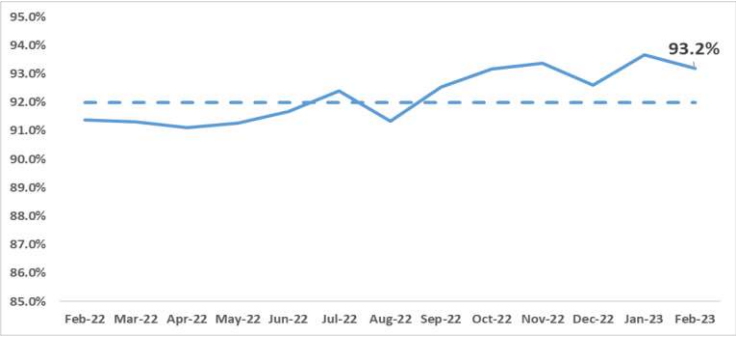
Section I: Urgent Care

Total Emergency admissions





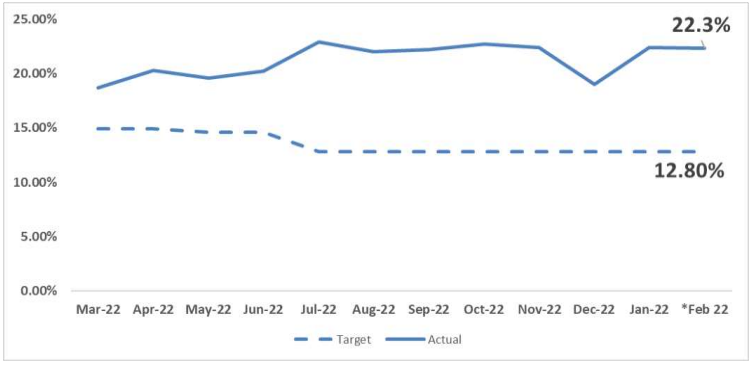
Bed Occupancy General & Acute



Organisation	Nov-22	Dec-22	Jan-23	* Feb-23
Cheshire & Merseyside	93.4%	92.6%	93.7%	93.2%
North West	93.5%	93.3%	93.7%	
England	94.3%	94.2%	94.3%	

* - Daily average to 10th February

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



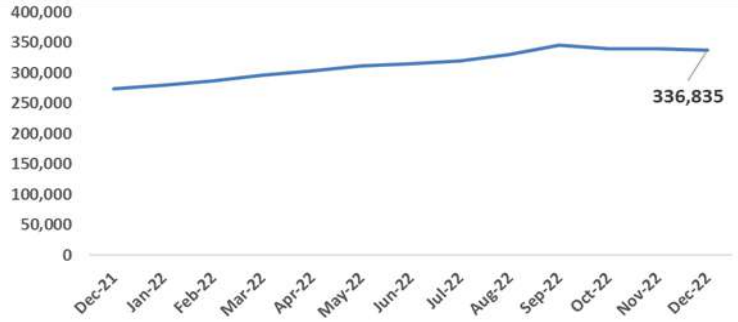
Organisation	Dec-22	Jan-23	Feb-23
Cheshire & Merseyside	19.0%	22.4%	22.3%

No longer meeting criteria to reside - Trust	12/03/2023
Countess of Chester Hospital	27.3%
East Cheshire Hospitals	13.9%
Liverpool University Hospitals	23.7%
Mid Cheshire Hospitals	18.6%
Southport & Ormskirk Hospital	9.8%
St Helens & Knowsley Hospital	16.9%
Warrington & Halton Hospital	24.1%
Wirral University Teaching Hospital	27.1%

NHS
Cheshire and Merseyside

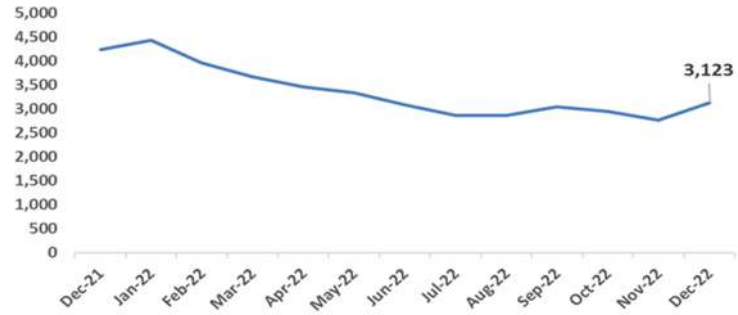
Section II: Planned Care

Total Waiting List Size



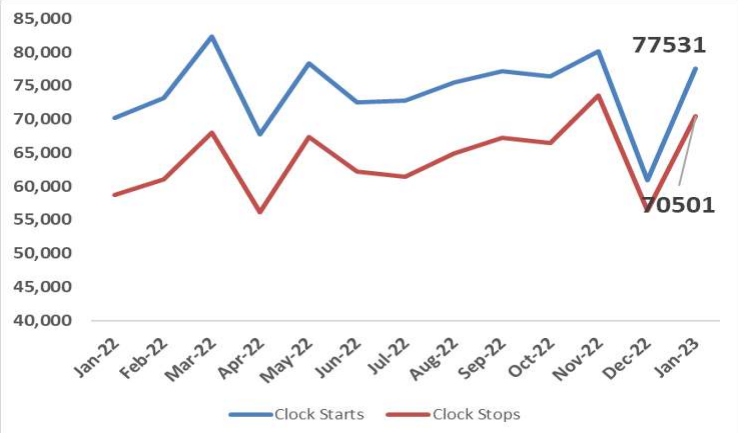
Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	339,746	339,619	336,835
North West	804,964	805,231	802,128
England	6,469,872	6,440,864	6,513,531

The number of people waiting 78 Weeks or more



Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	2952	2768	3123
North West	7219	7357	8102
England	42107	40872	46335

RTT – Clock Starts & Clock Stops

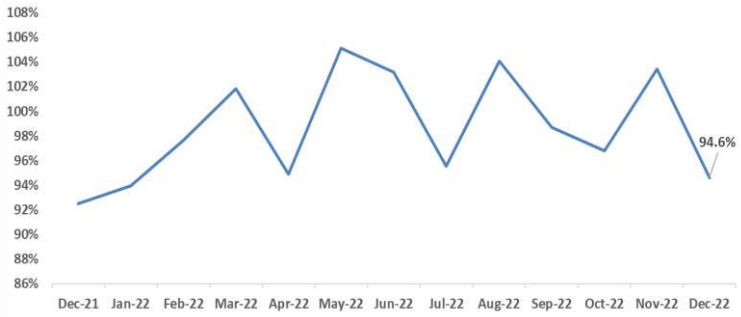


Cheshire & Merseyside	Nov-22	Dec-22	Jan-23
Clock Starts	80153	60931	77531
Clock Stops	73573	56349	70501

NB: Clock starts and clock stops for RTT treatment give a broad but not complete picture of additions and removals from the waiting list, as waiting lists are also subject to ongoing data validation.

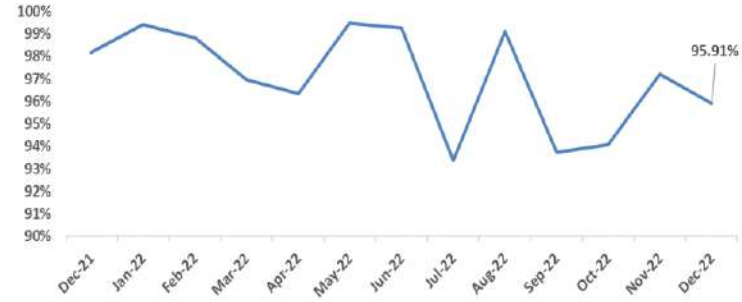
Section II: Planned Care

Outpatient First % of pre-COVID activity – Dec 22 (comparison with 2019/20)



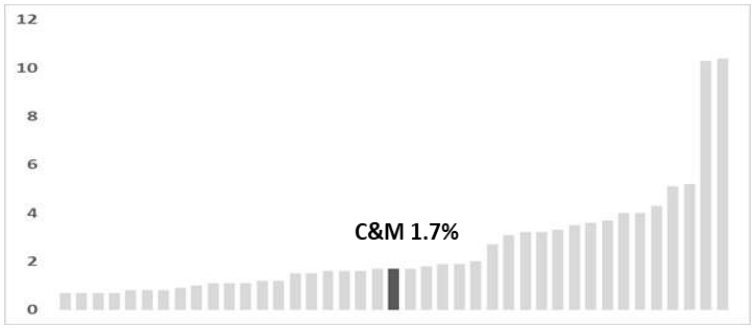
Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	96.77%	103.41%	94.61%
North West	87.54%	93.14%	88.87%
England	96.77%	99.34%	95.07%

Outpatient Follow-up % of pre-COVID activity – Dec 22 (comparison with 2019/20)



Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	94.08%	97.21%	95.91%
North West	91.02%	94.88%	93.90%
England	98.47%	100.62%	98.83%

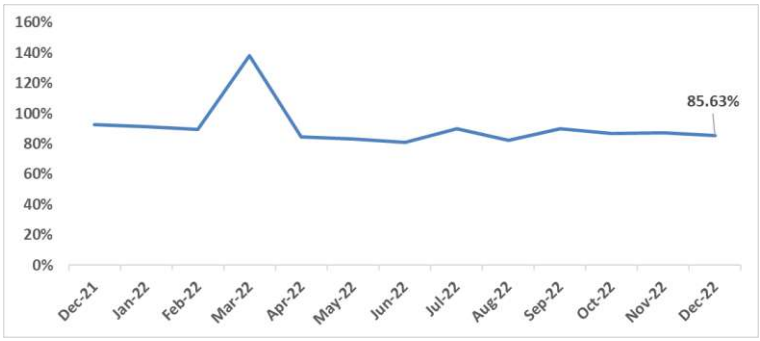
Patient Initiated Follow-up (PIFU) ICS Benchmark – Dec 22



Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	2.0%	1.8%	1.7%
North West	1.5%	1.5%	1.4%
England	1.8%	1.9%	1.9%

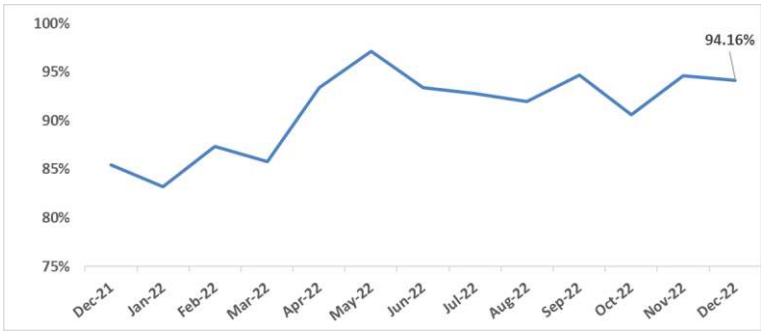
Section II: Planned Care

Elective inpatient admissions % of pre-COVID activity - Dec 22 (comparison with 2019/20)



Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	86.98%	87.25%	85.63%
North West	88.25%	87.33%	92.26%
England	84.61%	82.76%	84.75%

Day cases % of pre-COVID activity – Dec 22 (comparison with 2019/20)



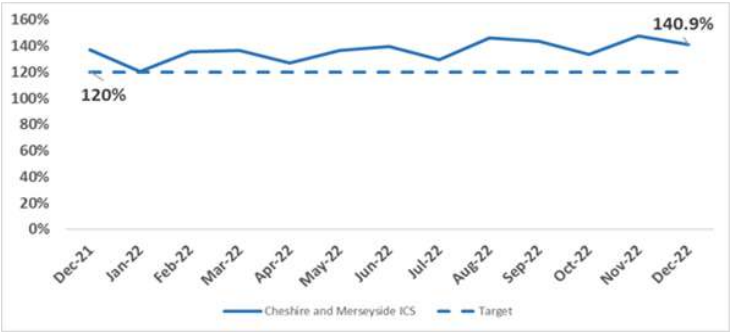
Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	90.57%	94.58%	94.16%
North West	89.70%	90.92%	92.68%
England	100.18%	98.08%	97.39%

Elective Recovery Fund – Value-weighted elective activity

SUS Value + A&G	30-Apr-22	31-May-22	30-Jun-22	31-Jul-22	31-Aug-22	30-Sep-22	31-Oct-22	30-Nov-22	31-Dec-22
North West	91.6%	94.3%	92.2%	93.0%	92.7%	90.5%	92.2%	92.7%	92.8%
LANCASHIRE AND SOUTH CUMBRIA ICB	*94.6%*	*99.4%*	*95.3%*	*97.7%*	*97.5%*	*98.7%*	*98.0%*	*95.8%*	*97.4%*
GREATER MANCHESTER ICB	*90.1%*	*89.7%*	*89.6%*	*89.5%*	*87.9%*	*82.6%*	*86.8%*	*87.5%*	*88.6%*
CHESHIRE AND MERSEYSIDE ICB	*91.4%*	*96.3%*	*93.0%*	*94.1%*	*95.0%*	*94.1%*	*94.4%*	*96.4%*	*94.5%*
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	91.0%	96.5%	90.7%	94.1%	99.4%	96.7%	94.5%	99.8%	112.7%
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	94.5%	99.5%	98.1%	99.5%	101.3%	99.9%	96.5%	96.3%	90.3%
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	103.0%	109.4%	106.8%	101.7%	119.1%	106.2%	114.6%	96.5%	88.0%
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	97.6%	95.7%	99.6%	103.2%	92.6%	91.6%	102.0%	97.1%	96.2%
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	88.6%	98.2%	90.4%	84.8%	91.8%	91.3%	93.9%	96.3%	100.0%
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	89.9%	91.5%	89.6%	91.4%	89.7%	94.4%	87.5%	98.5%	89.4%
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	102.4%	105.0%	102.0%	104.6%	100.6%	100.7%	100.5%	100.3%	100.8%
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	97.9%	100.8%	92.0%	93.9%	95.8%	89.3%	100.6%	103.8%	90.3%
THE WALTON CENTRE NHS FOUNDATION TRUST	84.5%	111.6%	104.6%	107.8%	102.2%	104.5%	110.7%	112.4%	94.0%
EAST CHESHIRE NHS TRUST	72.2%	81.4%	80.0%	75.6%	84.4%	85.0%	85.9%	89.8%	99.0%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	89.9%	85.5%	82.7%	83.8%	87.6%	83.3%	91.5%	90.6%	90.2%
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	89.3%	92.0%	89.6%	90.8%	89.4%	95.6%	97.2%	102.8%	92.5%
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	89.7%	96.2%	95.4%	93.4%	93.2%	91.4%	87.2%	87.5%	85.3%
England	94.1%	96.8%	94.8%	95.5%	95.3%	96.4%	97.3%	96.6%	95.4%

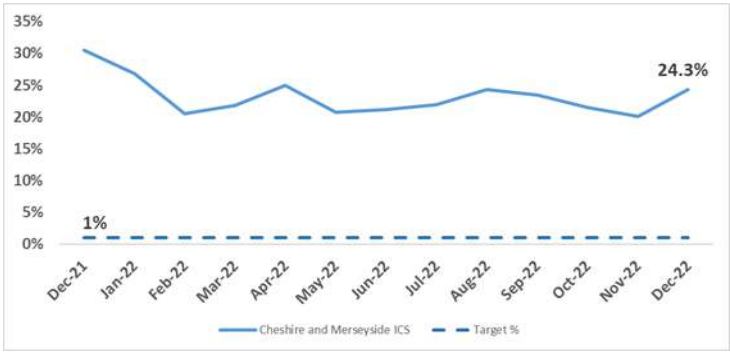
Section II: Planned Care

Diagnostic Activity: % of pre-COVID activity – Compared to same month in 2019



Organisation	Oct-22	Nov-22	Dec-22
Cheshire & Merseyside	133.4%	147.5%	140.9%
North West	100.2%	109.7%	102.5%
England			

Diagnostic 6 week wait – objective no more than 1%



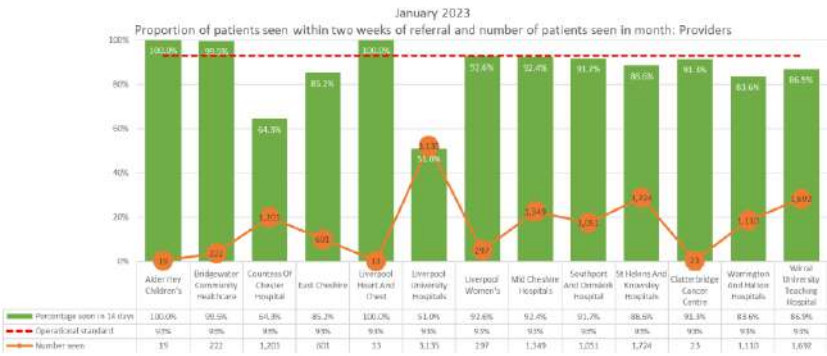
Organisation	Oct-22	Nov-22	Dec-22
Cheshire & Merseyside	21.5%	20.0%	24.3%
North West	28.4%	20.8%	24.3%
England	30.7%	26.5%	31.5%

Section III: Cancer Care

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

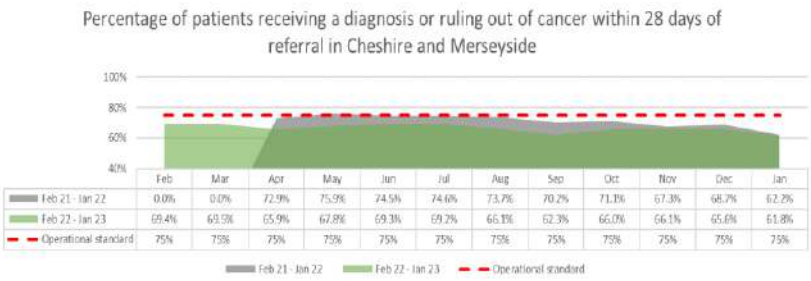
*Note: This metric shows numbers of patients seen in Cheshire & Merseyside, meaningful comparisons to numbers seen in the North West or England cannot be made.

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



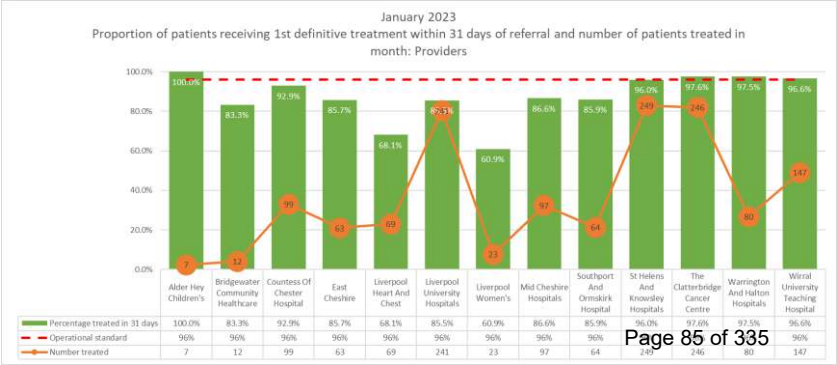
Organisation	Nov-22	Dec-22	Jan-22
Cheshire & Merseyside	77.5%	76.8%	76.9%
North West	74.9%	75.1%	
England	78.8%	80.3%	81.8%

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



Organisation	Nov-22	Dec-22	Jan-22
Cheshire & Merseyside	66.1%	65.6%	61.8%
North West	64.4%	66.2%	
England	69.7%	70.7%	67.0%

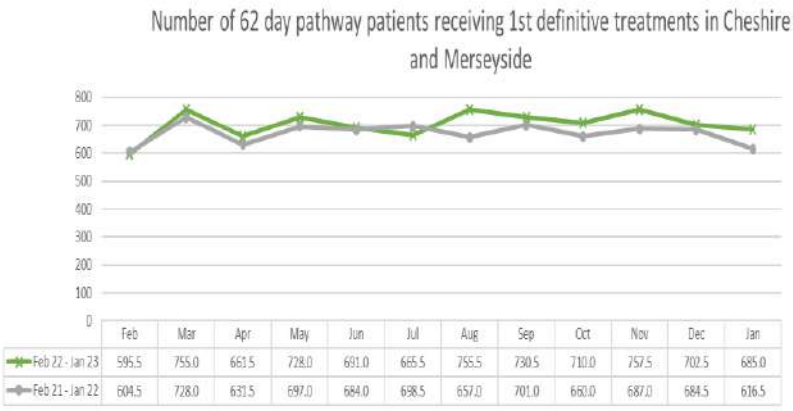
% of patients diagnosed with cancer receiving treatment within 31 days of diagnosis



Organisation	Nov-22	Dec-22	Jan-22
Cheshire & Merseyside	94.0%	95.1%	90.8%
North West	92.9%	93.6%	
England	91.6%	92.7%	88.5%

Section III: Cancer Care

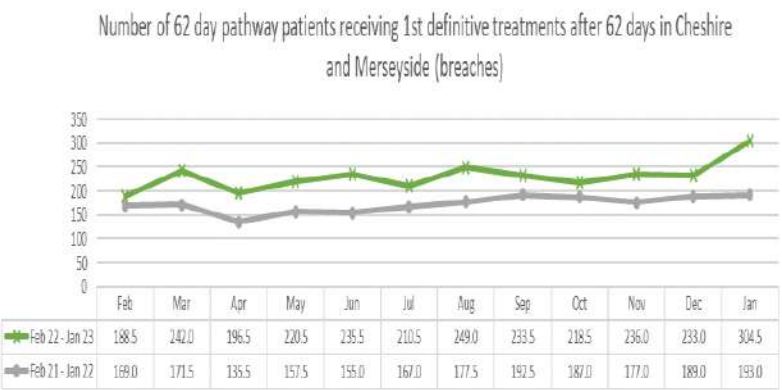
Number of patients receiving treatment for cancer treatment by their GP waiting on 62 day pathway



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Feb 22 - Jan 23	595.5	755.0	661.5	728.0	691.0	665.5	755.5	730.5	710.0	757.5	702.5	685.0
Feb 21 - Jan 22	604.5	728.0	631.5	697.0	684.0	698.5	657.0	701.0	660.0	687.0	684.5	616.5

*Note: This metric shows numbers of patients seen in Cheshire & Merseyside, meaningful comparisons to numbers seen in the North West or England cannot be made.

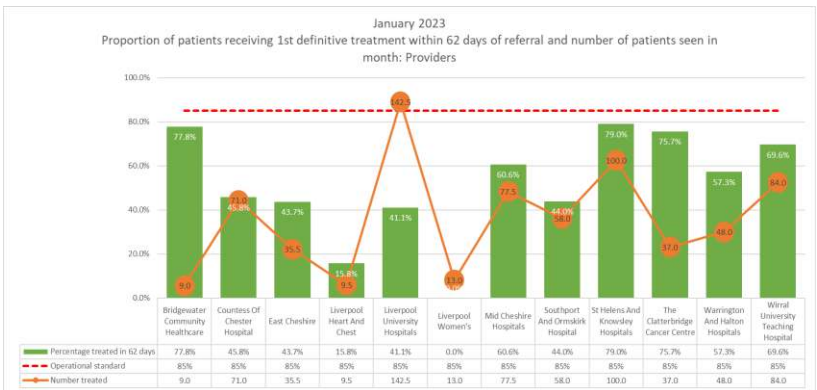
% Patients referred for cancer treatment by their GP waiting more than 62 days for treatment to start



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Feb 22 - Jan 23	188.5	242.0	196.5	220.5	235.5	210.5	249.0	233.5	218.5	236.0	233.0	304.5
Feb 21 - Jan 22	169.0	171.5	135.5	157.5	155.0	167.0	177.5	192.5	187.0	177.0	189.0	193.0

Organisation	Nov-22	Dec-22	Jan-22
Cheshire & Merseyside	68.8%	66.8%	55.6%
North West	63.1%	63.4%	
England	61.0%	61.8%	54.4%

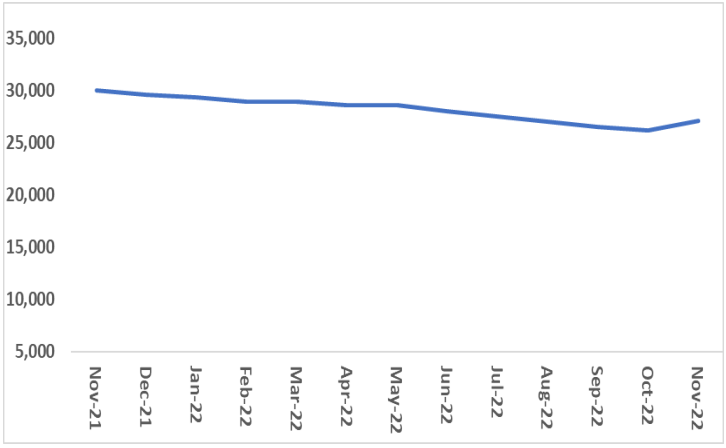
% Patients referred for cancer treatment by their GP waiting more than 62 days for treatment to start - Providers



	Bridgewater Community Healthcare	Countess Of Chester Hospital	East Cheshire	Liverpool Heart And Chest	Liverpool University Hospitals	Liverpool Women's	Mid Cheshire Hospitals	Southport And Ormskirk Hospital	St Helens And Knowsley Hospitals	The Clatterbridge Cancer Centre	Warrington And Halton Hospitals	Wirral University Teaching Hospital
Percentage treated in 62 days	77.8%	45.8%	43.7%	15.8%	41.1%	0.0%	60.6%	44.0%	79.0%	75.7%	57.3%	69.6%
Operational standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Number treated	9.0	71.0	35.5	9.5	142.5	13.0	77.5	58.0	100.0	37.0	48.0	84.0

Section IV: Mental Health

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

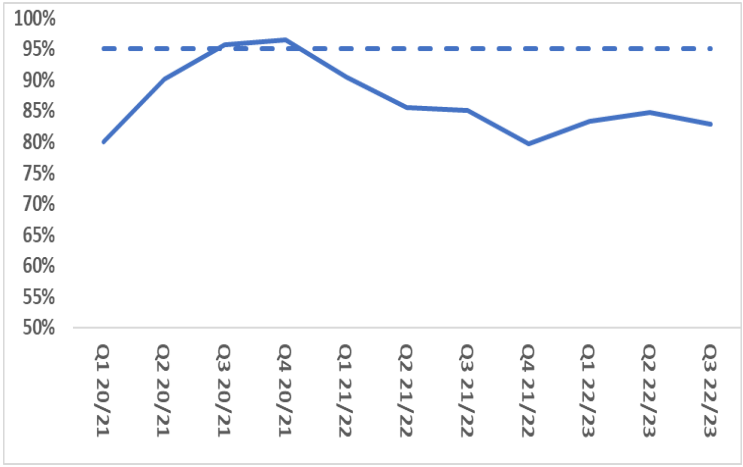


Organisation		Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	-		26,190	27,050
North West	-		93,075	95,100
England		697,350	701,658	708,939

source: NHS futures core data pack

A cyber incident affected NHSE ability to process national level data from August 22 onwards, national level data cannot be considered an accurate reflection of activity. NHS Digital has produced estimates for the affected months

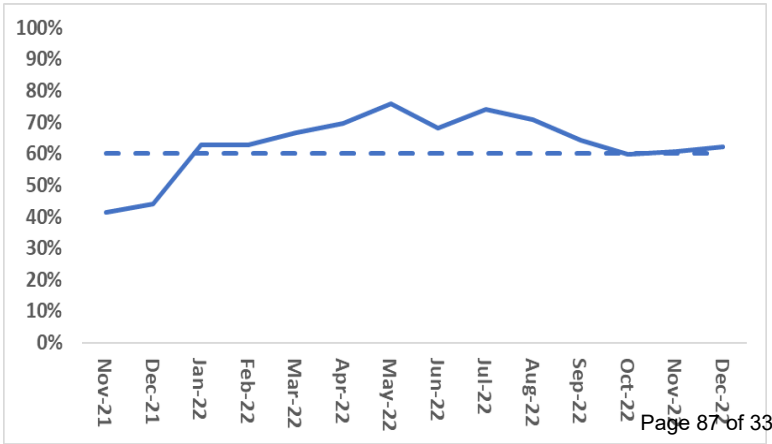
% of children and young people with eating disorders seen within 1 week (Urgent): *rolling 12 months



Organisation	Q1 22/23	Q2 22/23	Q3 22/23
Cheshire and Merseyside	83.3%	84.80%	82.80%
North West	84.6% -		86.80%
England	68.1%	67.10%	77.50%
* 12 months to end of quarter			

A cyber incident affected NHSE ability to process national level data from August 22 onwards, national level data cannot be considered an accurate reflection of activity. NHS Digital has produced estimates for the affected months

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

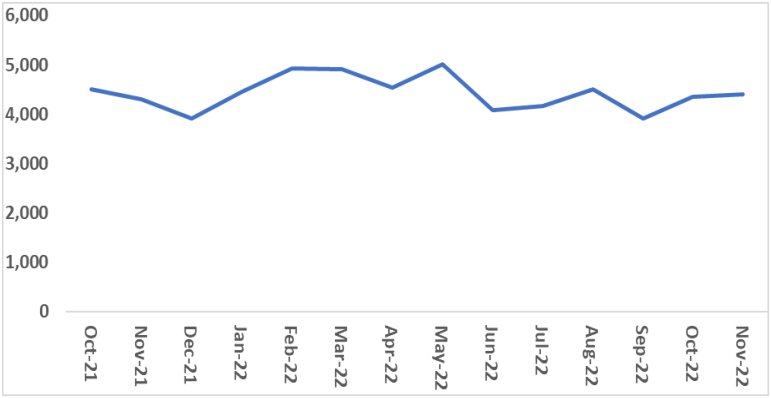


Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	64.30%	59.40%	60.70%
North West		62.30%	65.10%
England	70.40%	72.20%	72.20%

National/regional benchmarking a month in arrears

Section IV: Mental Health

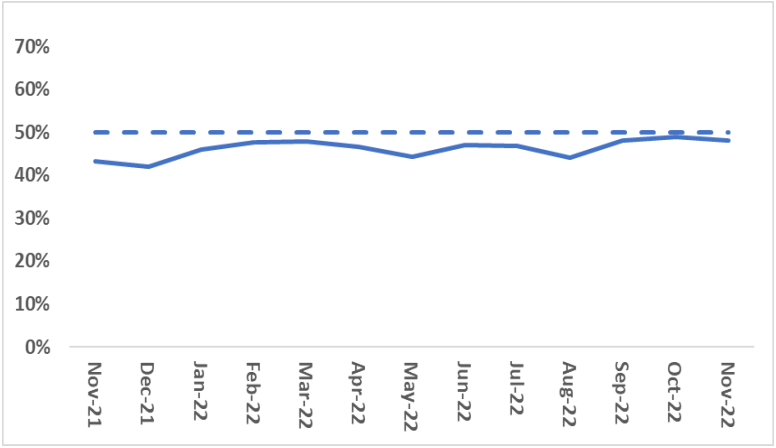
IAPT access: No of people entering NHS funded treatment



Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	3,915	4,360	4,395
North West	12,605	14,625	15,025
England	95,023	102,971	113,385

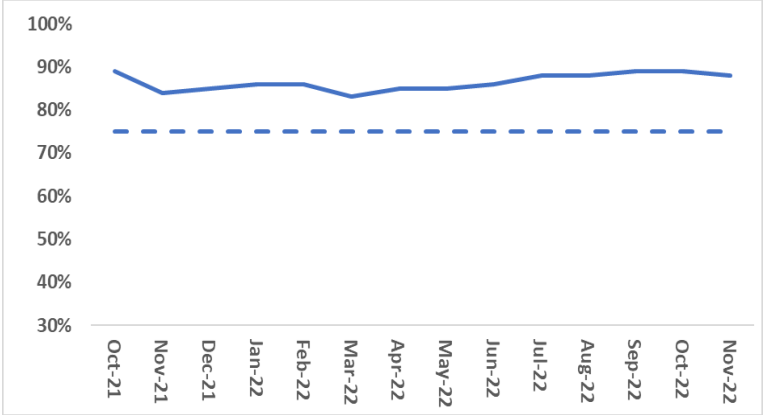
source: NHS futures core data pack

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



Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	48.0%	49.0%	48.0%
North West	49.0%	47.0%	48.0%
England	49.8%	49.2%	49.5%

IAPT 6 week waits: * % finished treatment in the reporting period who had first treatment within 6 weeks



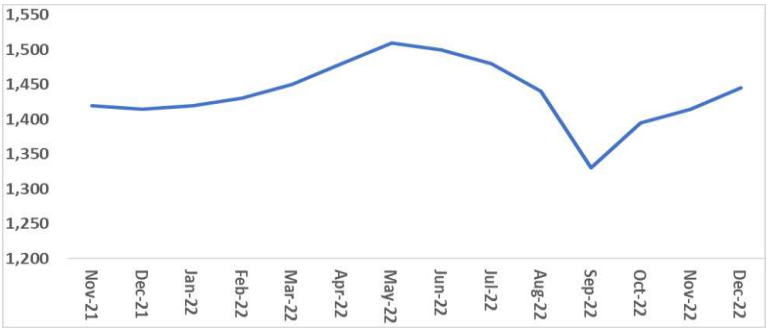
Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	89.0%	89.0%	88.0%
North West	84.0%	82.0%	81.0%
England	89.3%	89.2%	89.1%

**source : NHS futures MH Core Data Pack*

NHS
Cheshire and Merseyside

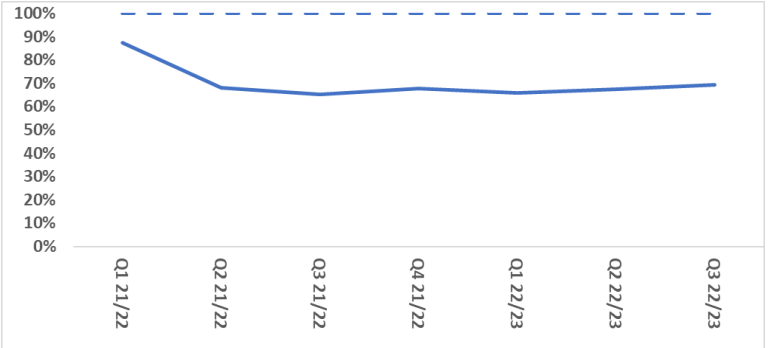
Section IV: Mental Health

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



Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	1,395	1,415	1,445
North West	5,600	5,655	5,710
England	45,245	45,475	45,560

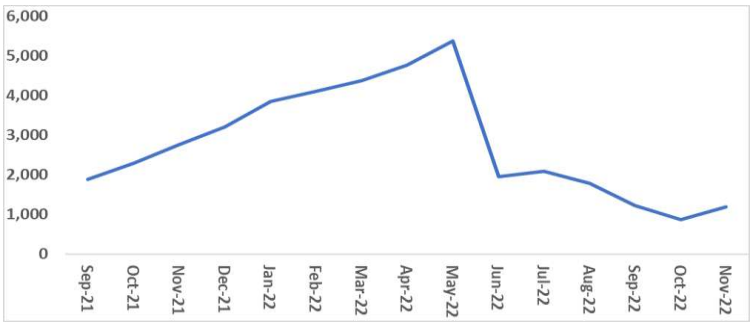
Physical health checks for people with severe mental illness



Organisation	Q1 22/23	Q2 22/23	Q3 22/23
Cheshire and Merseyside	65.9%	67.6%	69.3%
North West	73.2%	73.9%	74.7%
England	73.2%	74.5%	76.5%

** metric calculation has changed in line with SOF definition – denominator is LTP indicative trajectory (weighted share of national LTP ambition 22/23*

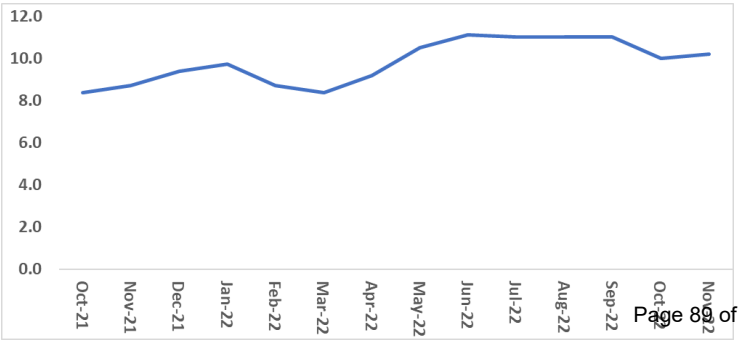
Total number of inappropriate adult acute mental health out of area placements bed days : rolling 3 month periods



Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	1,230	865	1,190
North West	4,590	4,876	5,780
England	54,865	57,255	60,205

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 18-64 with a length of stay of 60+ days *rolling Qtr



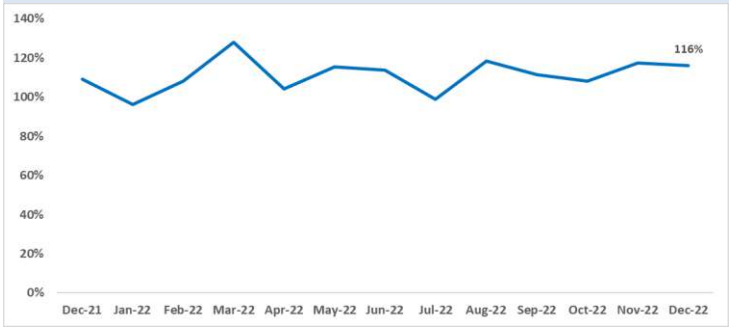
Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	-	10.00	10.20
North West	-	10.90	10.80
England	8.70	8.50	8.90

rolling qtr (MH core data pack)

A cyber incident affected NHSE ability to process national level data from August 22 onwards, national level data cannot be considered an accurate reflection of activity

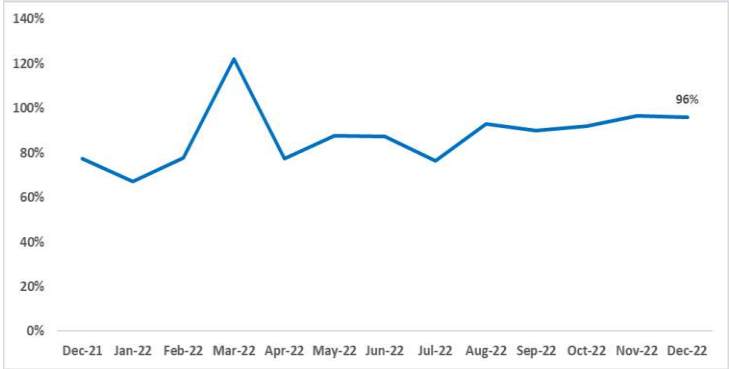
Section V: Primary Care

Total appointments delivered against pre-covid baseline



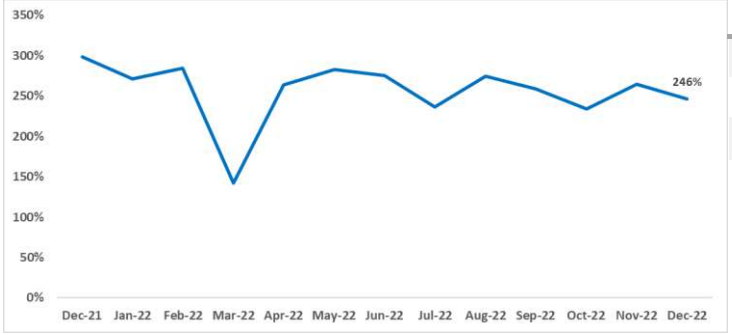
Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	108.2%	117.4%	116.2%
North West	123.9%	120.0%	118.6%
England	121.0%	118.1%	114.8%

Face to Face appointments delivered against pre covid baseline



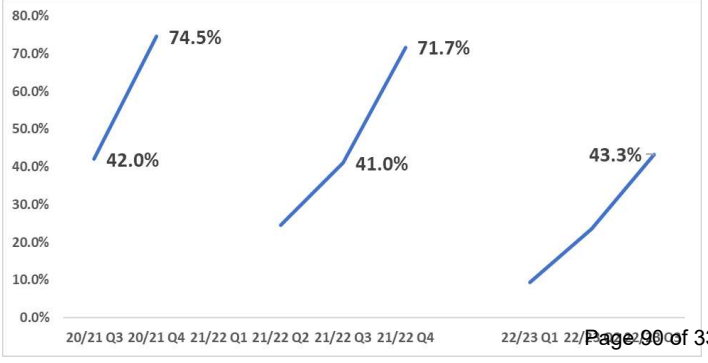
Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	91.8%	96.5%	95.7%
North West	94.8%	100.9%	99.8%
England	93.8%	100.3%	97.3%

Telephone appointments delivered against pre-covid baseline



Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	233.6%	264.9%	246.3%
North West	266.1%	294.2%	276.0%
England	215.4%	239.5%	228.5%

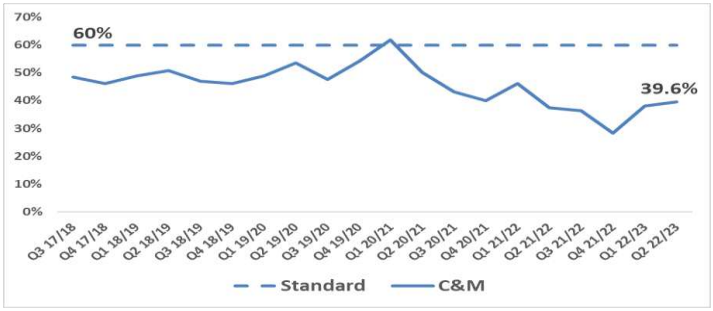
Number of people aged 14+with a learning disability on the GP register receiving an annual health check



Organisation	Q1 22/23	Q2 22/23	Q3 22/23
Cheshire & Merseyside	9.4%	23.6%	43.3%
North West	9.3%	24.1%	44.8%
England	10.4%	26.0%	46.0%

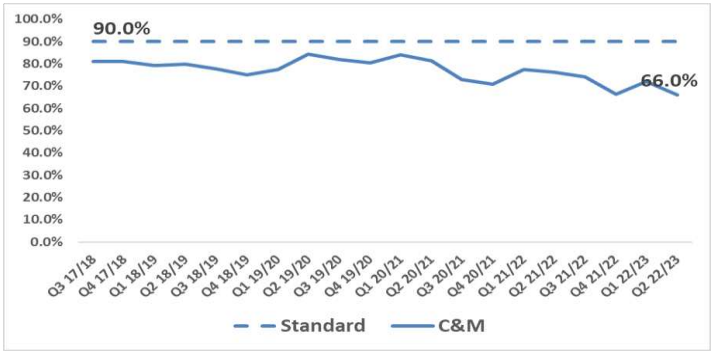
Section VI: Quality Care

Admitted to stroke unit <4 hours



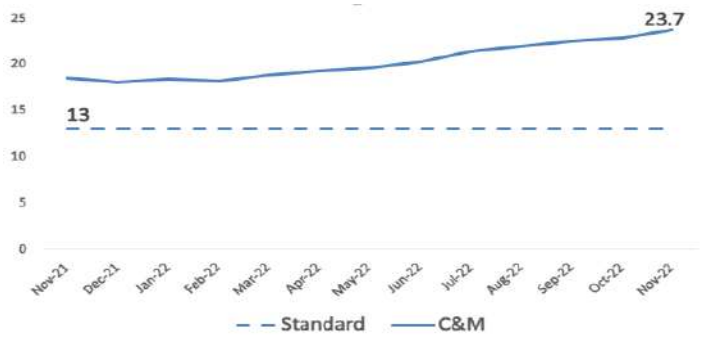
Organisation	Q4 21/22	Q1 22/23	Q2 22/23
Cheshire & Merseyside	28.2%	37.9%	39.6%
North West	36.3%	40.6%	39.9%
England	38.2%	38.6%	37.9%

Spent >90% of time on stroke unit



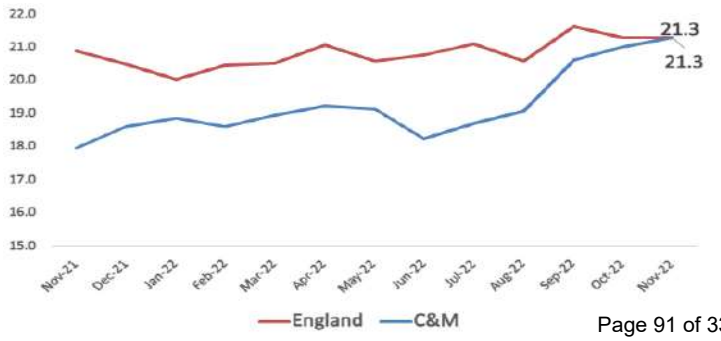
Organisation	Q4 21/22	Q1 22/23	Q2 22/23
Cheshire & Merseyside	66.3%	71.9%	66.0%
North West	68.2%	75.0%	72.5%
England	73.1%	74.2%	75.8%

C.Difficile (Hospital Onset)



Organisation	Sep-22	Oct-22	Nov-22
Cheshire & Merseyside	22.5	22.9	23.7
North West	25.6	26.0	27.3
England	18.6	18.8	19.3

E.Coli (Hospital Onset)

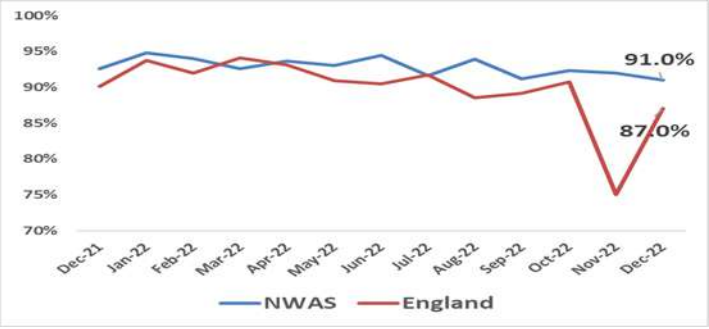


Organisation	Sep-22	Oct-22	Nov-22
Cheshire & Merseyside	20.6	21.0	21.3
North West	22.4	22.7	23.2
England	21.6	21.3	21.3

NHS
Cheshire and Merseyside

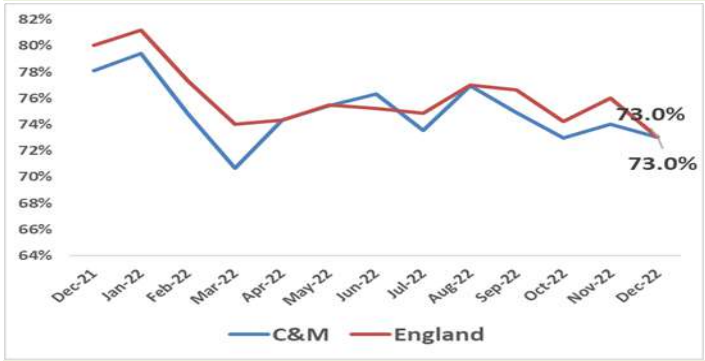
Section VI: Quality Care

Friends & Family – Ambulance Service



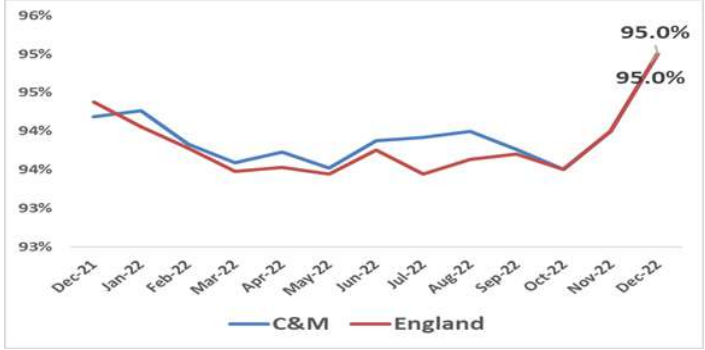
Organisation	Oct-22	Nov-22	Dec-22
NWAS	92.36%	92.00%	91.00%
England	90.76%	75.00%	87.00%

Friends & Family score – A&E



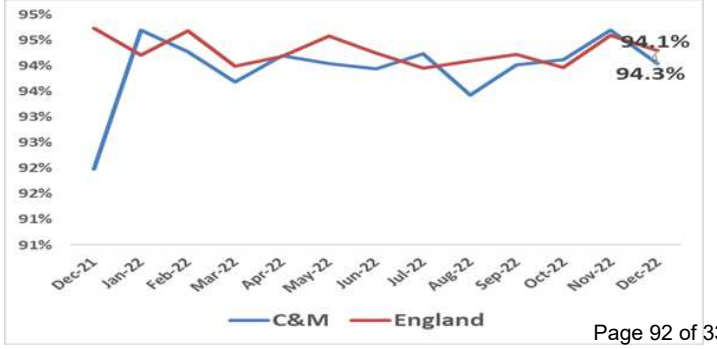
Organisation	Oct-22	Nov-22	Dec-22
Cheshire & Merseyside	73%	74%	73%
England	74%	76%	73%

Friends & Family score – Outpatient



Organisation	Oct-22	Nov-22	Dec-22
Cheshire & Merseyside	94%	94%	95%
England	94%	94%	95%

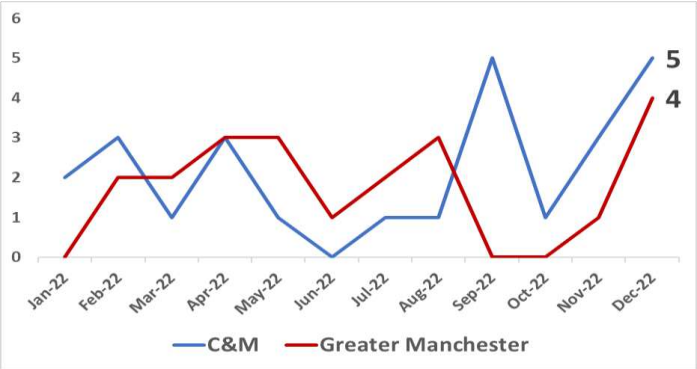
Friends & Family score – Inpatient

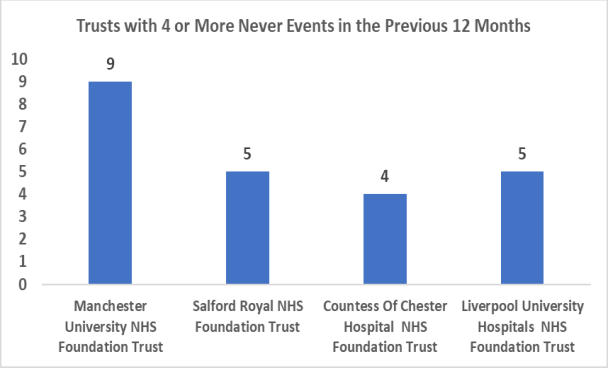


Organisation	Oct-22	Nov-22	Dec-22
Cheshire & Merseyside	94.1%	94.7%	94.1%
England	94.0%	94.6%	94.3%

Section VI: Quality Care

Never Events





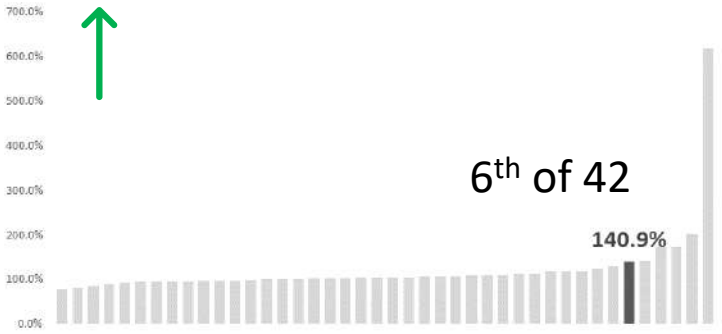
Deterioration since July 22

Improvement since July 22

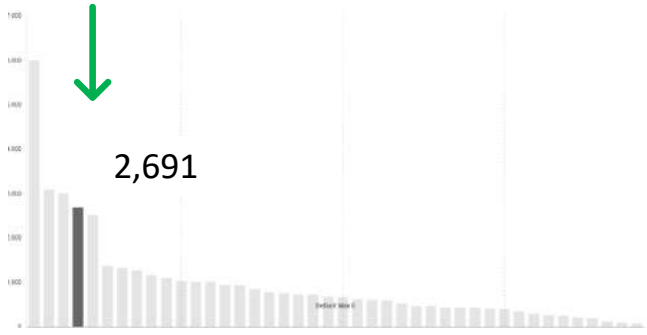
NHS Cheshire and Merseyside

ICB – National Performance Ambition Metrics

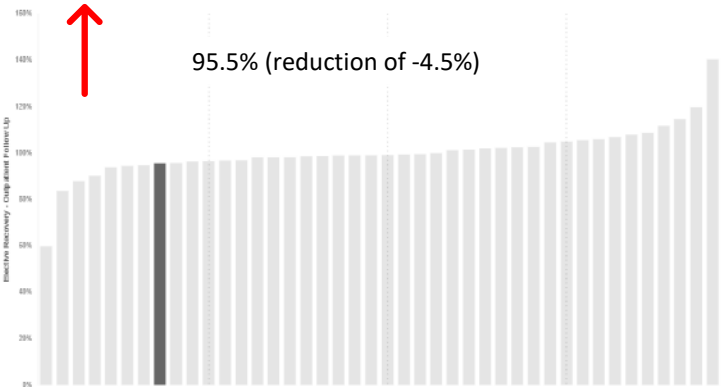
Increase diagnostic activity to 120% pre-pandemic levels



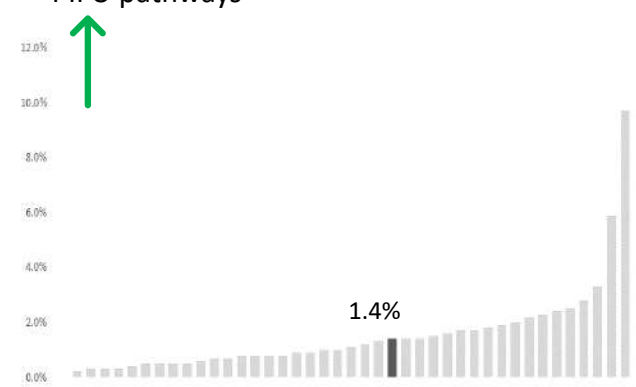
Eliminate 78 week waiters by the end of March 2023



-25% reduction in outpatient follow up attendances

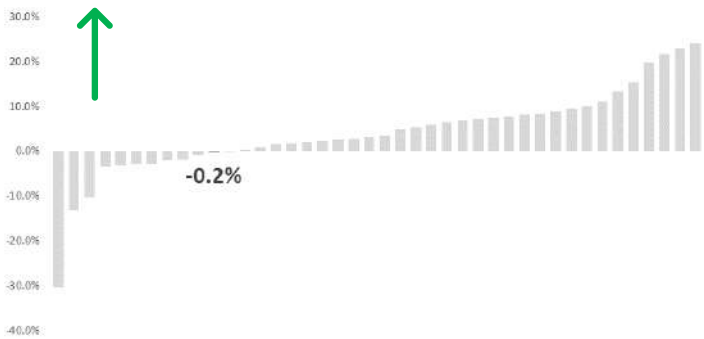


5% of outpatient attendances to convert to PIFU pathways

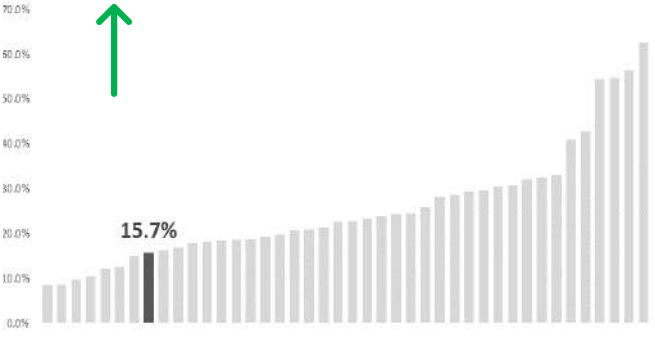


10% more patients to complete treatment through a combination of completed pathways (4% via clock stops and 6% via Advice & Guidance deflections)

Clock stops



Advice & Guidance



Deterioration since July 22

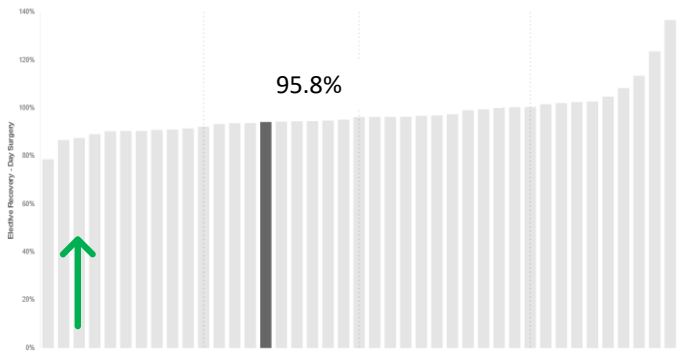
Improvement since July 22

Cheshire and Merseyside

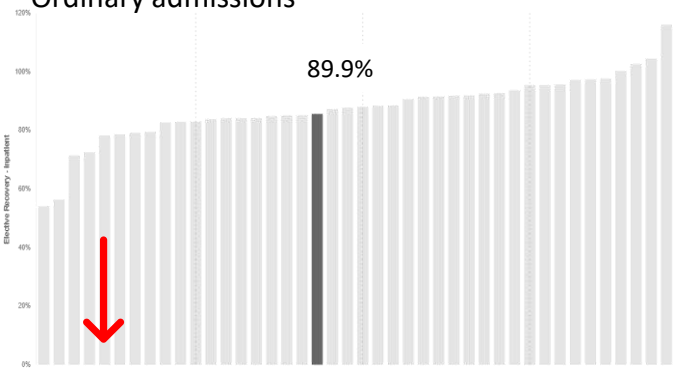
ICB – National Performance Ambition Metrics

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

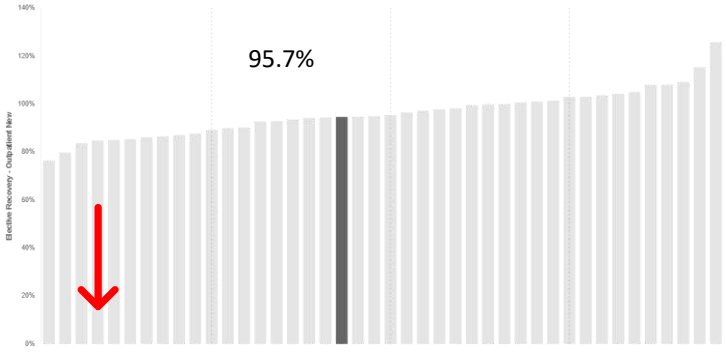
Day case



Ordinary admissions



Outpatient new



Deterioration since July 22

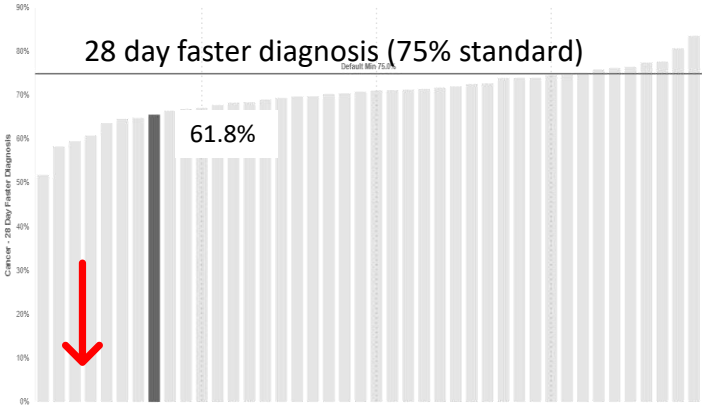
Improvement since July 22

NHS Cheshire and Merseyside

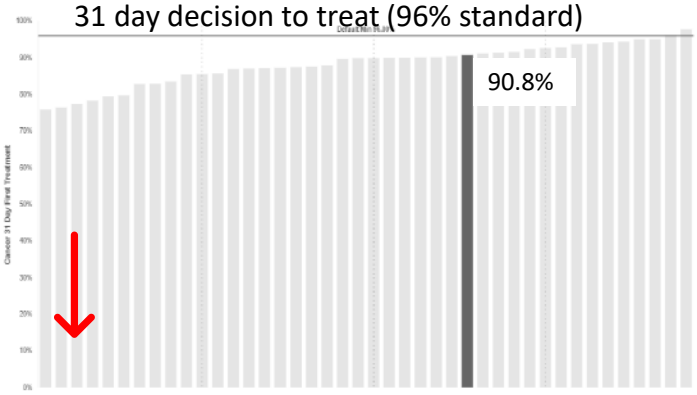
ICB – National Performance Ambition Metrics

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)

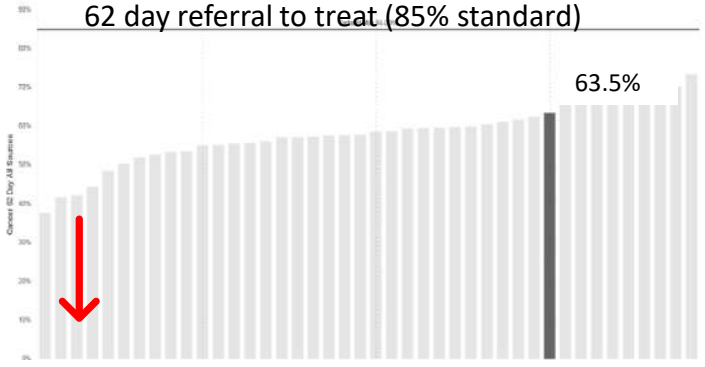
28 day faster diagnosis (75% standard)



31 day decision to treat (96% standard)



62 day referral to treat (85% standard)



NHS
Cheshire and Merseyside

Appendix 2 – Provider Summaries

NHS
Cheshire and Merseyside

Warrington & Halton Hospital Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Jan 23	95.00%	**64.5%**
A&E Attendances All	Jan 23	-	9,473
Breast Feeding Initiation	Oct 22	70.0%	**57.9%**
C.difficile (Hospital Onset)	Nov 22	13.00	**22.8**
Cancelled Operations	Q3 22/23	0.65%	0.2%
Cancer - 28 Day Faster Diagnosis	Dec 22	75.0%	**73.6%**
Cancer 2 Week Wait	Dec 22	93.00%	**85.1%**
Cancer 2 Week Wait Breast Symptomatic	Dec 22	93.0%	100%
Cancer 31 Day First Treatment	Dec 22	96.00%	98.5%
Cancer 62 Day Classic	Dec 22	85.00%	**73.8%**
Day Surgery Activity	Dec 22	-	1,900
Diagnostics - 6 Week Standard	Dec 22	1.00%	**28.9%**
E.coli (All Cases)	Nov 22	-	116.6
Elective Inpatient Activity	Dec 22	-	245
Mixed Sex Accommodation Breaches	Dec 22	0	**8**
MRSA (All Cases)	Nov 22	-	2.6
MSSA (All Cases)	Nov 22	-	36.8
Outpatient Follow Up Activity	Dec 22	-	24,935
Outpatient New Activity	Dec 22	-	6,660
Outpatient Total Activity	Dec 22	-	31,595
RTT 104 Week Breach	Dec 22	0	**2**
RTT 52 Week Breach	Dec 22	0	**1,458**
RTT 78 Week Breach	Dec 22	0	**228**
RTT Incomplete 18 Week Standard	Dec 22	92.00%	**57.3%**
RTT Total Incompletes	Dec 22	-	29,028
Sickness Absence Rate	Sep 22	4.00%	**5.5%**
Staff Recommend Care	Q3 21/22	80.00%	**63.7%**
Summary Hospital Mortality Indicator	Sep 22	100.00	97.3

NHS
Cheshire and Merseyside

Wirral University Teaching Hospital Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Jan 23	95.00%	**65.7%**
A&E Attendances All	Jan 23	-	9,644
Breast Feeding Initiation	Oct 22	70.0%	**50.0%**
C.difficile (Hospital Onset)	Nov 22	13.00	**47.3**
Cancelled Operations	Q3 22/23	0.65%	**0.9%**
Cancer - 28 Day Faster Diagnosis	Dec 22	75.0%	76.2%
Cancer 2 Week Wait	Dec 22	93.00%	**87.9%**
Cancer 2 Week Wait Breast Symptomatic	Dec 22	93.0%	**-**
Cancer 31 Day First Treatment	Dec 22	96.00%	**95.3%**
Cancer 62 Day Classic	Dec 22	85.00%	**74.0%**
Day Surgery Activity	Dec 22	-	3,605
Diagnostics - 6 Week Standard	Dec 22	1.00%	**13.3%**
E.coli (All Cases)	Nov 22	-	97.3
Elective Inpatient Activity	Dec 22	-	540
Mixed Sex Accommodation Breaches	Dec 22	0	**1**
MRSA (All Cases)	Nov 22	-	2.4
MSSA (All Cases)	Nov 22	-	31.9
Outpatient Follow Up Activity	Dec 22	-	26,995
Outpatient New Activity	Dec 22	-	9,970
Outpatient Total Activity	Dec 22	-	36,965
RTT 104 Week Breach	Dec 22	0	0
RTT 52 Week Breach	Dec 22	0	**1,321**
RTT 78 Week Breach	Dec 22	0	**71**
RTT Incomplete 18 Week Standard	Dec 22	92.00%	**57.8%**
RTT Total Incompletes	Dec 22	-	37,460
Sickness Absence Rate	Sep 22	4.00%	**6.4%**
Staff Recommend Care	Q3 21/22	80.00%	**67.8%**
Summary Hospital Mortality Indicator	Sep 22	100.00	**106.3**

NHS
Cheshire and Merseyside

St Helens & Knowsley Hospital Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Jan 23	95.00%	**66.1%**
A&E Attendances All	Jan 23	-	12,868
Breast Feeding Initiation	Oct 22	70.0%	**48.4%**
C.difficile (Hospital Onset)	Nov 22	13.00	**14.2**
Cancelled Operations	Q3 22/23	0.65%	**1.0%**
Cancer - 28 Day Faster Diagnosis	Dec 22	75.0%	**65.1%**
Cancer 2 Week Wait	Dec 22	93.00%	**83.3%**
Cancer 2 Week Wait Breast Symptomatic	Dec 22	93.0%	**93.0%**
Cancer 31 Day First Treatment	Dec 22	96.00%	97.2%
Cancer 62 Day Classic	Dec 22	85.00%	**76.9%**
Day Surgery Activity	Dec 22	-	3,380
Diagnostics - 6 Week Standard	Dec 22	1.00%	**32.5%**
E.coli (All Cases)	Nov 22	-	93.4
Elective Inpatient Activity	Dec 22	-	390
Mixed Sex Accommodation Breaches	Dec 22	0	0
MRSA (All Cases)	Nov 22	-	1.5
MSSA (All Cases)	Nov 22	-	38.9
Outpatient Follow Up Activity	Dec 22	-	25,375
Outpatient New Activity	Dec 22	-	12,450
Outpatient Total Activity	Dec 22	-	37,825
RTT 104 Week Breach	Dec 22	0	0
RTT 52 Week Breach	Dec 22	0	**2,515**
RTT 78 Week Breach	Dec 22	0	**491**
RTT Incomplete 18 Week Standard	Dec 22	92.00%	**62.8%**
RTT Total Incompletes	Dec 22	-	44,851
Sickness Absence Rate	Sep 22	4.00%	3.3%
Staff Recommend Care	Q3 21/22	80.00%	**79.4%**
Summary Hospital Mortality Indicator	Sep 22	100.00	**102.7**

NHS
Cheshire and Merseyside

Mid Cheshire Hospitals Summary

The trust have reported no patients waiting over 104 weeks for the second month. Despite more activity in most diagnostic modalities in 2022 compared to pre-pandemic, the backlog has increased slightly. Performance against the majority of Cancer targets for the trust remain above England and Cheshire & Merseyside averages.

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Jan 23	95.00%	**59.4%**
A&E Attendances All	Jan 23	-	8,541
Breast Feeding Initiation	Oct 22	70.0%	**65.5%**
C.difficile (Hospital Onset)	Nov 22	13.00	**15.6**
Cancelled Operations	Q3 22/23	0.65%	**1.2%**
Cancer - 28 Day Faster Diagnosis	Dec 22	75.0%	**66.3%**
Cancer 2 Week Wait	Dec 22	93.00%	**92.3%**
Cancer 2 Week Wait Breast Symptomatic	Dec 22	93.0%	**72.7%**
Cancer 31 Day First Treatment	Dec 22	96.00%	**92.5%**
Cancer 62 Day Classic	Dec 22	85.00%	**68.4%**
Day Surgery Activity	Dec 22	-	2,080
Diagnostics - 6 Week Standard	Dec 22	1.00%	**30.0%**
E.coli (All Cases)	Nov 22	-	103.5
Elective Inpatient Activity	Dec 22	-	200
Mixed Sex Accommodation Breaches	Dec 22	0	0
MRSA (All Cases)	Nov 22	-	2.0
MSSA (All Cases)	Nov 22	-	32.2
Outpatient Follow Up Activity	Dec 22	-	15,920
Outpatient New Activity	Dec 22	-	7,310
Outpatient Total Activity	Dec 22	-	23,230
RTT 104 Week Breach	Dec 22	0	0
RTT 52 Week Breach	Dec 22	0	**1,730**
RTT 78 Week Breach	Dec 22	0	**100**
RTT Incomplete 18 Week Standard	Dec 22	92.00%	**55.6%**
RTT Total Incompletes	Dec 22	-	36,235
Sickness Absence Rate	Sep 22	4.00%	**5.1%**
Staff Recommend Care	Q3 21/22	80.00%	**71.9%**
Summary Hospital Mortality Indicator	Sep 22	100.00	94.4

NHS
Cheshire and Merseyside

Liverpool University Hospitals Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Jan 23	95.00%	**68.6%**
A&E Attendances All	Jan 23	-	24,670
C.difficile (Hospital Onset)	Nov 22	13.00	**25.6**
Cancelled Operations	Q3 22/23	0.65%	**1.2%**
Cancer - 28 Day Faster Diagnosis	Dec 22	75.0%	**58.1%**
Cancer 2 Week Wait	Dec 22	93.00%	**48.4%**
Cancer 2 Week Wait Breast Symptomatic	Dec 22	93.0%	**32.6%**
Cancer 31 Day First Treatment	Dec 22	96.00%	**94.8%**
Cancer 62 Day Classic	Dec 22	85.00%	**60.3%**
Day Surgery Activity	Dec 22	-	5,095
Diagnostics - 6 Week Standard	Dec 22	1.00%	**23.0%**
E.coli (All Cases)	Nov 22	-	118.3
Elective Inpatient Activity	Dec 22	-	960
Mixed Sex Accommodation Breaches	Dec 22	0	0
MRSA (All Cases)	Nov 22	-	2.1
MSSA (All Cases)	Nov 22	-	36.2
Outpatient Follow Up Activity	Dec 22	-	43,820
Outpatient New Activity	Dec 22	-	22,665
Outpatient Total Activity	Dec 22	-	66,485
RTT 104 Week Breach	Dec 22	0	**18**
RTT 52 Week Breach	Dec 22	0	**9,589**
RTT 78 Week Breach	Dec 22	0	**1,744**
RTT Incomplete 18 Week Standard	Dec 22	92.00%	**46.9%**
RTT Total Incompletes	Dec 22	-	85,426
Sickness Absence Rate	Sep 22	4.00%	**6.1%**
Staff Recommend Care	Q3 21/22	80.00%	**60.3%**
Summary Hospital Mortality Indicator	Sep 22	100.00	**102.1**

NHS
Cheshire and Merseyside

East Cheshire Hospitals Summary

Significant progress continues with the utilisation of Independent Sector capacity, specifically within Gastroenterology, ENT, General Surgery and T&O specialties and some theatre lists are being converted to support long waiting patients. The cancer 62 day performance has seen a continuation of challenged performance. This is multi-factorial with the main impacts being the challenges of complex diagnostic pathways, delays in radiology as well as the reporting of histology.

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Jan 23	95.00%	**56.5%**
A&E Attendances All	Jan 23	-	3,786
C.difficile (Hospital Onset)	Nov 22	13.00	**13.8**
Cancelled Operations	Q3 22/23	0.65%	0.3%
Cancer - 28 Day Faster Diagnosis	Dec 22	75.0%	**65.7%**
Cancer 2 Week Wait	Dec 22	93.00%	**85.4%**
Cancer 2 Week Wait Breast Symptomatic	Dec 22	93.0%	**75.9%**
Cancer 31 Day First Treatment	Dec 22	96.00%	**74.0%**
Cancer 62 Day Classic	Dec 22	85.00%	**48.7%**
Day Surgery Activity	Dec 22	-	835
Diagnostics - 6 Week Standard	Dec 22	1.00%	**25.2%**
E.coli (All Cases)	Nov 22	-	107.9
Elective Inpatient Activity	Dec 22	-	90
Mixed Sex Accommodation Breaches	Dec 22	0	0
MRSA (All Cases)	Nov 22	-	1.7
MSSA (All Cases)	Nov 22	-	42.3
Outpatient Follow Up Activity	Dec 22	-	4,755
Outpatient New Activity	Dec 22	-	4,030
Outpatient Total Activity	Dec 22	-	8,785
RTT 104 Week Breach	Dec 22	0	**3**
RTT 52 Week Breach	Dec 22	0	**175**
RTT 78 Week Breach	Dec 22	0	**18**
RTT Incomplete 18 Week Standard	Dec 22	92.00%	**64.3%**
RTT Total Incompletes	Dec 22	-	10,895
Sickness Absence Rate	Sep 22	4.00%	**5.8%**
Staff Recommend Care	Q3 21/22	80.00%	**64.6%**
Summary Hospital Mortality Indicator	Sep 22	100.00	**116.6**

NHS
Cheshire and Merseyside

Countess of Chester Hospital Summary

The trust upgraded from an outdated electronic patient record (EPR) system to a new EPR system in 2021. Data issues have impacted on availability of data and the trust's ability to manage waiting lists effectively, leading to poor performance across the majority of areas.
Issue: Data, once migrated from the old system, was not visible on the new system, leading to ongoing use of manual records.
Action: Detailed validation of patient records across every service and all points of delivery (POD), eg Out Patients, Inpatients etc. commenced in November 2021 and is expected to be completed by December 2022.
Mitigation: As at September 2022 validation of Diagnostic data is almost complete and good progress has been made on validating RTT, particularly Open Pathways. In addition there is notable improvements to TCI data and Outpatient Follow Ups (FUPs). The trust are also working with NHS digital to ensure data from the new system is loading accurately onto the "Spine".
For cancer the trust have implemented a process/pathway review, leadership restructure and overhaul of operational reporting governance.

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Jan 23	95.00%	**60.0%**
A&E Attendances All	Jan 23	-	6,203
Breast Feeding Initiation	Oct 22	70.0%	70.6%
C.difficile (Hospital Onset)	Nov 22	13.00	**34.6**
Cancelled Operations	Q3 22/23	0.65%	**0.8%**
Cancer - 28 Day Faster Diagnosis	Dec 22	75.0%	**61.0%**
Cancer 2 Week Wait	Dec 22	93.00%	**66.0%**
Cancer 2 Week Wait Breast Symptomatic	Dec 22	93.0%	**-**
Cancer 31 Day First Treatment	Dec 22	96.00%	100%
Cancer 62 Day Classic	Dec 22	85.00%	**69.6%**
Day Surgery Activity	Dec 22	-	1,970
Diagnostics - 6 Week Standard	Dec 22	1.00%	**20.8%**
E.coli (All Cases)	Nov 22	-	120.7
Elective Inpatient Activity	Dec 22	-	200
Mixed Sex Accommodation Breaches	Dec 22	0	**5**
MRSA (All Cases)	Nov 22	-	1.4
MSSA (All Cases)	Nov 22	-	42.0
Outpatient Follow Up Activity	Dec 22	-	18,305
Outpatient New Activity	Dec 22	-	6,760
Outpatient Total Activity	Dec 22	-	25,065
RTT 104 Week Breach	Dec 22	0	**5**
RTT 52 Week Breach	Dec 22	0	**3,388**
RTT 78 Week Breach	Dec 22	0	**268**
RTT Incomplete 18 Week Standard	Dec 22	92.00%	**42.9%**
RTT Total Incompletes	Dec 22	-	37,170
Sickness Absence Rate	Sep 22	4.00%	**5.5%**
Staff Recommend Care	Q3 21/22	80.00%	**57.1%**
Summary Hospital Mortality Indicator	Sep 22	100.00	98.3

NHS
Cheshire and Merseyside

Southport & Ormskirk Hospital Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Jan 23	95.00%	**75.9%**
A&E Attendances All	Jan 23	-	9,620
Breast Feeding Initiation	Oct 22	70.0%	**55.3%**
C.difficile (Hospital Onset)	Nov 22	13.00	**24.7**
Cancelled Operations	Q3 22/23	0.65%	**1.7%**
Cancer - 28 Day Faster Diagnosis	Dec 22	75.0%	**67.4%**
Cancer 2 Week Wait	Dec 22	93.00%	**91.3%**
Cancer 2 Week Wait Breast Symptomatic	Dec 22	93.0%	**-**
Cancer 31 Day First Treatment	Dec 22	96.00%	**87.7%**
Cancer 62 Day Classic	Dec 22	85.00%	**51.3%**
Day Surgery Activity	Dec 22	-	1,505
Diagnostics - 6 Week Standard	Dec 22	1.00%	**25.5%**
E.coli (All Cases)	Nov 22	-	140.7
Elective Inpatient Activity	Dec 22	-	150
Mixed Sex Accommodation Breaches	Dec 22	0	**9**
MRSA (All Cases)	Nov 22	-	1.5
MSSA (All Cases)	Nov 22	-	49.3
Outpatient Follow Up Activity	Dec 22	-	12,525
Outpatient New Activity	Dec 22	-	4,850
Outpatient Total Activity	Dec 22	-	17,375
RTT 104 Week Breach	Dec 22	0	0
RTT 52 Week Breach	Dec 22	0	**175**
RTT 78 Week Breach	Dec 22	0	**9**
RTT Incomplete 18 Week Standard	Dec 22	92.00%	**60.9%**
RTT Total Incompletes	Dec 22	-	16,002
Sickness Absence Rate	Sep 22	4.00%	**5.8%**
Staff Recommend Care	Q3 21/22	80.00%	**52.8%**
Summary Hospital Mortality Indicator	Sep 22	100.00	**100.4**

NHS
Cheshire and Merseyside

Liverpool Women's Hospital Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Jan 23	95.00%	**88.1%**
A&E Attendances All	Jan 23	-	1,342
Breast Feeding Initiation	Oct 22	70.0%	**67.8%**
C.difficile (Hospital Onset)	Nov 22	13.00	0.0
Cancelled Operations	Q3 22/23	0.65%	**1.6%**
Cancer - 28 Day Faster Diagnosis	Dec 22	75.0%	**49.5%**
Cancer 2 Week Wait	Dec 22	93.00%	**87.7%**
Cancer 31 Day First Treatment	Dec 22	96.00%	**69.6%**
Cancer 62 Day Classic	Dec 22	85.00%	**14.3%**
Day Surgery Activity	Dec 22	-	330
Diagnostics - 6 Week Standard	Dec 22	1.00%	**19.5%**
E.coli (All Cases)	Nov 22	-	42.9
Elective Inpatient Activity	Dec 22	-	115
Mixed Sex Accommodation Breaches	Dec 22	0	0
MRSA (All Cases)	Nov 22	-	0.0
MSSA (All Cases)	Nov 22	-	3.6
Outpatient Follow Up Activity	Dec 22	-	6,300
Outpatient New Activity	Dec 22	-	3,925
Outpatient Total Activity	Dec 22	-	10,225
RTT 104 Week Breach	Dec 22	0	0
RTT 52 Week Breach	Dec 22	0	**2,706**
RTT 78 Week Breach	Dec 22	0	**194**
RTT Incomplete 18 Week Standard	Dec 22	92.00%	**41.7%**
RTT Total Incompletes	Dec 22	-	17,850
Sickness Absence Rate	Sep 22	4.00%	**7.3%**
Staff Recommend Care	Q3 21/22	80.00%	**69.1%**

NHS
Cheshire and Merseyside

Liverpool Heart & Chest Hospital Summary

Key Performance Indicator	Period	Target	
C.difficile (Hospital Onset)	Nov 22	13.00	3.9
Cancelled Operations	Q3 22/23	0.65%	**4.1%**
Cancer - 28 Day Faster Diagnosis	Dec 22	75.0%	**50.0%**
Cancer 2 Week Wait	Dec 22	93.00%	100%
Cancer 31 Day First Treatment	Dec 22	96.00%	97.6%
Cancer 62 Day Classic	Dec 22	85.00%	91.7%
Day Surgery Activity	Dec 22	-	255
Diagnostics - 6 Week Standard	Dec 22	1.00%	**1.1%**
E.coli (All Cases)	Nov 22	-	15.8
Elective Inpatient Activity	Dec 22	-	235
Mixed Sex Accommodation Breaches	Dec 22	0	0
MRSA (All Cases)	Nov 22	-	0.0
MSSA (All Cases)	Nov 22	-	27.6
Outpatient Follow Up Activity	Dec 22	-	3,620
Outpatient New Activity	Dec 22	-	2,035
Outpatient Total Activity	Dec 22	-	5,655
RTT 104 Week Breach	Dec 22	0	0
RTT 52 Week Breach	Dec 22	0	**56**
RTT 78 Week Breach	Dec 22	0	**9**
RTT Incomplete 18 Week Standard	Dec 22	92.00%	**74.4%**
RTT Total Incompletes	Dec 22	-	4,948
Sickness Absence Rate	Sep 22	4.00%	**5.0%**
Staff Recommend Care	Q3 21/22	80.00%	91.6%

NHS
Cheshire and Merseyside

Alder Hey Hospital Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Jan 23	95.00%	**76.3%**
A&E Attendances All	Jan 23	-	5,175
C.difficile (Hospital Onset)	Nov 22	13.00	0.0
Cancelled Operations	Q3 22/23	0.65%	**1.4%**
Cancer - 28 Day Faster Diagnosis	Dec 22	75.0%	100%
Cancer 2 Week Wait	Dec 22	93.00%	100%
Cancer 31 Day First Treatment	Dec 22	96.00%	100%
Cancer 62 Day Classic	Dec 22	85.00%	-
Day Surgery Activity	Dec 22	-	1,490
Diagnostics - 6 Week Standard	Dec 22	1.00%	**28.8%**
E.coli (All Cases)	Nov 22	-	46.8
Elective Inpatient Activity	Dec 22	-	265
Mixed Sex Accommodation Breaches	Dec 22	0	0
MRSA (All Cases)	Nov 22	-	0.0
MSSA (All Cases)	Nov 22	-	25.7
Outpatient Follow Up Activity	Dec 22	-	13,210
Outpatient New Activity	Dec 22	-	5,110
Outpatient Total Activity	Dec 22	-	18,320
RTT 104 Week Breach	Dec 22	0	0
RTT 52 Week Breach	Dec 22	0	**353**
RTT 78 Week Breach	Dec 22	0	**11**
RTT Incomplete 18 Week Standard	Dec 22	92.00%	**54.0%**
RTT Total Incompletes	Dec 22	-	22,343
Sickness Absence Rate	Sep 22	4.00%	**5.7%**
Staff Recommend Care	Q3 21/22	80.00%	89.5%

NHS
Cheshire and Merseyside

The Walton Centre Summary

Key Performance Indicator	Period	Target	
C.difficile (Hospital Onset)	Nov 22	13.00	**13.5**
Cancelled Operations	Q3 22/23	0.65%	**3.3%**
Cancer - 28 Day Faster Diagnosis	Dec 22	75.0%	100%
Cancer 2 Week Wait	Dec 22	93.00%	100%
Cancer 31 Day First Treatment	Dec 22	96.00%	100%
Cancer 62 Day Classic	Dec 22	85.00%	-
Day Surgery Activity	Dec 22	-	600
Diagnostics - 6 Week Standard	Dec 22	1.00%	0.5%
E.coli (All Cases)	Nov 22	-	31.6
Elective Inpatient Activity	Dec 22	-	170
Mixed Sex Accommodation Breaches	Dec 22	0	0
MRSA (All Cases)	Nov 22	-	0.0
MSSA (All Cases)	Nov 22	-	20.3
Outpatient Follow Up Activity	Dec 22	-	5,670
Outpatient New Activity	Dec 22	-	2,620
Outpatient Total Activity	Dec 22	-	8,290
RTT 104 Week Breach	Dec 22	0	0
RTT 52 Week Breach	Dec 22	0	**118**
RTT 78 Week Breach	Dec 22	0	**9**
RTT Incomplete 18 Week Standard	Dec 22	92.00%	**77.1%**
RTT Total Incompletes	Dec 22	-	12,414
Sickness Absence Rate	Sep 22	4.00%	**5.4%**
Staff Recommend Care	Q3 21/22	80.00%	88.7%

NHS
Cheshire and Merseyside

The Clatterbridge Cancer Centre Summary

Key Performance Indicator	Period	Target	
C.difficile (Hospital Onset)	Nov 22	13.00	**39.3**
Cancer - 28 Day Faster Diagnosis	Dec 22	75.0%	77.8%
Cancer 2 Week Wait	Dec 22	93.00%	100%
Cancer 31 Day First Treatment	Dec 22	96.00%	98.8%
Cancer 62 Day Classic	Dec 22	85.00%	85.9%
Day Surgery Activity	Dec 22	-	335
Diagnostics - 6 Week Standard	Dec 22	1.00%	**5.3%**
E.coli (All Cases)	Nov 22	-	139.2
Elective Inpatient Activity	Dec 22	-	85
Mixed Sex Accommodation Breaches	Dec 22	0	0
MRSA (All Cases)	Nov 22	-	3.6
MSSA (All Cases)	Nov 22	-	64.3
Outpatient Follow Up Activity	Dec 22	-	37,700
Outpatient New Activity	Dec 22	-	1,360
Outpatient Total Activity	Dec 22	-	39,060
RTT 104 Week Breach	Dec 22	0	0
RTT 52 Week Breach	Dec 22	0	0
RTT 78 Week Breach	Dec 22	0	0
RTT Incomplete 18 Week Standard	Dec 22	92.00%	96.7%
RTT Total Incompletes	Dec 22	-	983
Sickness Absence Rate	Sep 22	4.00%	**5.3%**
Staff Recommend Care	Q3 21/22	80.00%	85.5%

NHS
Cheshire and Merseyside

Cheshire & Wirral Partnership Summary

Key Performance Indicator	Period	Target	
Day Surgery Activity	Dec 22	-	-
EIP Open Referrals Waiting < 2 Weeks	Dec 22	75.00%	**2.6%**
Elective Inpatient Activity	Dec 22	-	-
IAPT Face to Face	Nov 22	-	12%
IAPT Incomplete Waiting under 18 weeks	Nov 22	95.0%	**80.0%**
IAPT Incomplete Waiting under 6 weeks	Nov 22	75.0%	**65.6%**
IAPT Recovery Rate	Nov 22	50.0%	**48.5%**
IAPT Referrals	Nov 22	-	1,035
MH AWOL Episodes	Nov 22	-	-
MH Under 18 Bed Days on Adult Ward	Nov 22	-	-
Mixed Sex Accommodation Breaches	Dec 22	0	0
Outpatient Follow Up Activity	Dec 22	-	-
Outpatient New Activity	Dec 22	-	-
Outpatient Total Activity	Dec 22	-	-
Sickness Absence Rate	Sep 22	4.00%	**6.0%**
Staff Recommend Care	Q3 21/22	80.00%	**69.5%**

NHS
Cheshire and Merseyside

Mersey Care Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Jan 23	95.00%	98.1%
A&E Attendances All	Jan 23	-	11,611
Day Surgery Activity	Dec 22	-	-
EIP Open Referrals Waiting < 2 Weeks	Dec 22	75.00%	**30.0%**
Elective Inpatient Activity	Dec 22	-	-
IAPT Face to Face	Nov 22	-	-
IAPT Incomplete Waiting under 18 weeks	Nov 22	95.0%	98.7%
IAPT Incomplete Waiting under 6 weeks	Nov 22	75.0%	97.0%
IAPT Recovery Rate	Nov 22	50.0%	**46.3%**
IAPT Referrals	Nov 22	-	2,665
Mixed Sex Accommodation Breaches	Dec 22	0	0
Outpatient Follow Up Activity	Dec 22	-	-
Outpatient New Activity	Dec 22	-	-
Outpatient Total Activity	Dec 22	-	-
RTT 104 Week Breach	Dec 22	0	0
RTT 52 Week Breach	Dec 22	0	0
RTT 78 Week Breach	Dec 22	0	0
RTT Incomplete 18 Week Standard	Dec 22	92.00%	100%
RTT Total Incompletes	Dec 22	-	39
Sickness Absence Rate	Sep 22	4.00%	**7.8%**
Staff Recommend Care	Q3 21/22	80.00%	**67.0%**

NHS
Cheshire and Merseyside

Wirral Community Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Jan 23	95.00%	96.1%
A&E Attendances All	Jan 23	-	3,972
Cancer 31 Day First Treatment	Dec 22	96.00%	-
Cancer 62 Day Classic	Dec 22	85.00%	-
Diagnostics - 6 Week Standard	Dec 22	1.00%	**65.7%**
RTT 104 Week Breach	Dec 22	0	0
RTT 52 Week Breach	Dec 22	0	0
RTT 78 Week Breach	Dec 22	0	0
RTT Incomplete 18 Week Standard	Dec 22	92.00%	98.3%
RTT Total Incompletes	Dec 22	-	119
Sickness Absence Rate	Sep 22	4.00%	**6.2%**
Staff Recommend Care	Q3 21/22	80.00%	**72.8%**

NHS
Cheshire and Merseyside

Bridgewater Community Healthcare Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Jan 23	95.00%	**93.7%**
A&E Attendances All	Jan 23	-	3,155
Cancer - 28 Day Faster Diagnosis	Dec 22	75.0%	75.9%
Cancer 2 Week Wait	Dec 22	93.00%	98.8%
Cancer 31 Day First Treatment	Dec 22	96.00%	100%
Cancer 62 Day Classic	Dec 22	85.00%	87.5%
Day Surgery Activity	Dec 22	-	0
Diagnostics - 6 Week Standard	Dec 22	1.00%	**3.1%**
Elective Inpatient Activity	Dec 22	-	0
IAPT Incomplete Waiting under 18 weeks	Nov 22	95.0%	-
IAPT Incomplete Waiting under 6 weeks	Nov 22	75.0%	-
IAPT Recovery Rate	Nov 22	50.0%	-
IAPT Referrals	Nov 22	-	-
Mixed Sex Accommodation Breaches	Dec 22	0	-
Outpatient Follow Up Activity	Dec 22	-	5,460
Outpatient New Activity	Dec 22	-	1,285
Outpatient Total Activity	Dec 22	-	6,745
RTT 104 Week Breach	Dec 22	0	0
RTT 52 Week Breach	Dec 22	0	**8**
RTT 78 Week Breach	Dec 22	0	0
RTT Incomplete 18 Week Standard	Dec 22	92.00%	**34.7%**
RTT Total Incompletes	Dec 22	-	2,809
Sickness Absence Rate	Sep 22	4.00%	**5.7%**
Staff Recommend Care	Q3 21/22	80.00%	**77.7%**

NHS
Cheshire and Merseyside

C&M Place Summary:

Feb 23 System Oversight Framework publication

			SubICB							
NHS OF Metric Name Full	Aggregation Source	Period	NHS CHESHIRE (SUB ICB LOCATION) (27D)	NHS HALTON (SUB ICB LOCATION) (01F)	NHS KNOWSLEY (SUB ICB LOCATION) (01J)	NHS LIVERPOOL (SUB ICB LOCATION) (99A)	NHS SOUTH SEFTON (SUB ICB LOCATION) (01T)	NHS SOUTHPORT AND FORMBY (SUB ICB LOCATION) (01V)	NHS ST HELENS (SUB ICB LOCATION) (01X)	NHS WARRINGTON (SUB ICB LOCATION) (02E)	NHS WIRRAL (SUB ICB LOCATION) (12F)
S009a: Total patients waiting more than 52 weeks to start consultant led treatment	SubICB	2022 11	6,966	899	1,864	7,059	2,907	565	1,025	1,421	1,515
S009b: Total patients waiting more than 78 weeks to start consultant led treatment	SubICB	2022 11	611	126	282	900	385	69	143	183	89
S009c: Total patients waiting more than 104 weeks to start consultant led treatment	SubICB	2022 11	27	0	2	11	6	1	2	4	3
S010a: Total patients treated for cancer compared with the same point in 2019/20	SubICB	2022 11		139%	157.9%	88.1%	86.2%	99.2%	93.2%	114.7%	116.4%
S012a: Proportion of patients meeting the faster cancer diagnosis standard	SubICB	2022 11	63.2%	72.7%	66.8%	58.8%	63.8%	67.9%	68%	71.3%	73.5%
S013a: Diagnostic activity levels: Imaging	SubICB	2022 11	112.1%	109.4%	102.3%	108.3%	104.5%	107.3%	104.4%	102.4%	102.6%
S013b: Diagnostic activity levels: Physiological measurement	SubICB	2022 11	77.8%	78%	92%	85.8%	81.9%	119.2%	90.7%	69.1%	78.8%
S013c: Diagnostic activity levels: Endoscopy	SubICB	2022 11	75.3%	119.7%	144%	118.9%	88%	163.4%	118.9%	124.6%	105%
S013d: Diagnostic activity levels: Total	SubICB	2022 11	105.5%	107.3%	103.7%	106.9%	100.5%	112.4%	103.8%	100.4%	99.5%
S031a: Rate of personalised care interventions	SubICB	22-23 Q2	57.5 per 1,000	21.03 per 1,000	52.99 per 1,000	67.44 per 1,000	40.44 per 1,000	26.15 per 1,000	43.76 per 1,000	68.05 per 1,000	63.44 per 1,000
S032a: Personal health budgets	SubICB	22-23 Q1	0.61 per 1,000	1.57 per 1,000	0.97 per 1,000	0.41 per 1,000	0.54 per 1,000	0.71 per 1,000	12.85 per 1,000	1.02 per 1,000	0.45 per 1,000
S040a: Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	SubICB	2022 11	10	2	0	11	2	0	1	3	6
S041a: Clostridium difficile infection rate	SubICB	2022 11	126.8%	132.4%	98%	102.9%	110.2%	89.6%	88.8%	158.7%	165.3%
S042a: E. coli bloodstream infection rate	SubICB	2022 11	110.6%	98.9%	137.1%	127.1%	114.5%	113.1%	100.7%	119%	129.3%
S044a: Antimicrobial resistance: total prescribing of antibiotics in primary care	SubICB	Nov 2021 - Oct 2022	89%	109.2%	107.8%	104.9%	113.7%	95%	111.2%	89.8%	107.6%
S044b: Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	SubICB	Nov 2021 - Oct 2022	7.5%	6.74%	7.43%	8.28%	8.93%	9.21%	6.1%	6.53%	10.6%
S046a: Population vaccination coverage: MMR for two doses (5 year olds)	SubICB	22-23 Q1	91.5%	93.4%	78%	75.3%	83.1%	90.6%	89.2%	91.4%	89.2%
S047a: Proportion of people over 65 receiving a seasonal flu vaccinatio	SubICB	2022 10	72.4%	68.9%	66%	59.7%	62.4%	74.9%	64.6%	67.4%	68.8%
S050a: Cervical screening coverage : % females aged 25 - 64 attending screening within the target period	SubICB	21-22 Q4	75.5%	71.6%	72%	64.4%	69.5%	73.3%	72.5%	74.3%	72.8%
S053a: % of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy	SubICB	2021-22	88.4%	90.7%	91.6%	89%	88.9%	89.5%	90.7%	90.9%	90.6%
S053b: % of hypertension patients who are treated to target as per NICE guidance	SubICB	2021-22	60.7%	57.1%	53.6%	57.3%	52.3%	62.8%	58.1%	59%	57.7%
S053c: % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	SubICB	22-23 Q1	56.9%	58.8%	59.9%	60.8%	58.9%	51.6%	58%	54.9%	59.2%
S055a: Number GP referrals to NHS Digital weight management services per 100k population	SubICB	22-23 Q2	114.2 per 100,000	86.2 per 100,000	76.3 per 100,000	124.3 per 100,000	40.9 per 100,000	133 per 100,000	69.3 per 100,000	62.9 per 100,000	24.9 per 100,000
S061a: Access rate for IAPT services	SubICB	22-23 Q2	61.6%	61.7%	56.6%	49.7%	45.9%	49%	75.8%	56.5%	71.7%
S086a: Inappropriate adult acute mental health placement out of area placement bed days	SubICB	Aug 2022 - Oct 2022	640	0	0	35	0	0	0	0	190
S105a: Proportion of patients discharged from hospital to their usual place of residence	SubICB	2022 11	89.7%	96.5%	94.5%	94%	94.6%	92%	92.8%	94.9%	92.8%
S115a: Proportion of diabetes patients that have received all eight diabetes care processes	SubICB	21-22 Q4	42.9%	26.5%	31.8%	42.9%	32.4%	47.2%	26.9%	27.3%	30.9%

Rank Banding
- Highest performing quartile
- Interquartile range
- Lowest performing quartile

NHS
Cheshire and Merseyside

ICB – Provider SOF Segments

Updated 17th March 2023

Trust	Segment	Change from October 22
Liverpool Heart and Chest Hospital NHS Foundation Trust	1	↔
The Walton Centre NHS Foundation Trust	1	↔
Alder Hey Children's NHS Foundation Trust	2	↔
Bridgewater Community Healthcare NHS Foundation Trust	2	↔
Cheshire and Wirral Partnership NHS Foundation Trust	2	↑
Mersey Care NHS Foundation Trust	2	↔
Mid-Cheshire Hospital NHS Foundation Trust	2	↔
North West Ambulance Service NHS Trust	2	↔
Southport and Ormskirk Hospital NHS Trust	2	↔
St Helens and Knowsley Teaching Hospitals NHS Trust	2	↔
Warrington and Halton Teaching Hospitals NHS Foundation Trust	2	↔
Wirral Community Health and Care NHS Foundation Trust	2	↔
Clatterbridge Cancer Centre NHS Foundation Trust	2	↔
Countess of Chester NHS Foundation Trust	3	↔
East Cheshire NHS Trust	3	↔
Liverpool Women's Hospital NHS Foundation Trust	3	↔
Wirral University Teaching Hospital NHS Foundation Trust	3	↔
Liverpool University Hospitals NHS Foundation Trust	4	↔

https://www.england.nhs.uk/publication/nhs-oversight-framework-segmentation/

Key

Segment 1	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place-based and overall ICS priorities
Segment 2	Plans that have the support of system partners in place to address areas of challenge.Targeted support may be required to address specific identified issues
Segment 3	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence (or equivalent for NHS trusts)
Segment 4	In actual or suspected breach of the licence (or equivalent) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

30 March 2023

North West Specialised Commissioning Joint Working Agreement 2023 - 2024

Agenda Item No	**ICB/03/30/12**
Report author & contact details	Matthew Cunningham, Associate Director of Corporate Affairs and Governance
Report approved by (sponsoring Director)	Clare Watson, Assistant Chief Executive
Responsible Officer to take actions forward	Clare Watson, Assistant Chief Executive

Cheshire and Merseyside ICB
Integrated Care Board Meeting

North West Specialised Commissioning Joint Working Agreement 2023 - 2024

Executive Summary	From April 2023 a joint working model with NHS England (NHSE) will be legally underpinned by a Joint Working Agreement and statutory Joint Committee between NHSE and the three Integrated Care Boards (ICBs) in the North West for the 59 specialised services that are appropriate for more integrated commissioning. This report: • sets out the scope and scale of services that have been identified as suitable and ready for joint working arrangements from April 2023 • describe the oversight and joint decision-making arrangements in Cheshire and Merseyside in 2023/24 as a stepping-stone to receiving delegated full commissioning responsibility for suitable services, including budgets and financial liability from April 2024 (subject to NHSE's Board consideration and decision). • seeks approval from the Board to enter into a Joint Working Agreement and progress the establishment of statutory joint committee arrangements and approval to delegate authority to the Chief Executive and Assistant Chief Executive to sign the Joint Working Agreement on behalf of NHS Cheshire and Merseyside to enable these commissioning arrangements to 'go live' from April 2023. • Outlines briefly the progress being made to ensure the ICB is ready for full delegation from April 2024.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X	X	X		
Recommendation	**The Board is asked to:** • **note** the contents of the report the list of services in the North West that are appropriate for greater ICB leadership from April 2023, those that are likely to be appropriate at a future point in time, and those services where commissioning responsibility will be retained by NHSE • **approve** the ICB entering into a Joint Working Agreement and progressing the work to establish statutory joint committee arrangements with NHS England and NHS Greater Manchester and NHS Lancashire and South Cumbria ICBs for the 2023/24 period • **approve** delegating authority to the Assistant Chief Executive to sign the Joint Working Agreement on behalf of NHS Cheshire and Merseyside to enable these commissioning arrangements to 'go live' from April 2023 • **note** that further engagement will be undertaken with members of the three ICB Boards in developing and agreeing the Joint Committee Terms of Reference.				
Key issues	All three ICB Boards and NHSE are required to approve and sign the Joint Working Agreement prior to the 07 April 2023.				

	The Joint Committee Terms of Reference do not need to be approved prior to the signing of the Joint Working Agreement. Further work is required to populate and agree the Terms of Reference prior to approval by each Partner body and the formal establishment of the Joint Committee.
Key risks	No key risks identified with committing to sign up to the Joint Working Agreement. It is a requirement on all partner bodies to be signatories to the agreement to formalise the joint working arrangement. The liability, responsibility, and accountability for the commissioning of specialised services continues to reside with NHSE in 2023/24 however the Joint Working Arrangements as descried within this paper and within the Joint working Agreement outline the benefits and opportunities that greater involvement of ICBs within specialised services commissioning brings.

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

Route to this meeting	Updates on the delegation of specialised commissioning arrangements and joint working have been provided to the Board at its previous meetings throughout 2023/24. The content of this paper has been discussed via regular meetings with the NHSE North West Specialised Commissioning team and ICB leads. A version of this paper has gone to the Board of NHS Greater Manchester ICB at its meeting on 15 March 2023, where approval was received to form the Committee and sign the Joint Working Agreement, and the Board of NHS Lancashire and South Cumbria ICB at its meeting 29 March 2023 will also considering a similar paper with the same asks.
Management of Conflicts of Interest	Members of the Board will need to state any conflicts at the Board meeting.
Patient and Public Engagement	As a formal committee of ICBs and NHSE, the Joint Committee will also be required to observe the duties placed on NHS bodies regarding effective engagement with stakeholders, including patients and the public, and involving them in decision-making. The Committee is also required to ensure it has appropriate clinical advice and leadership, including through Clinical Reference Groups and Relevant Clinical Networks.

Equality, Diversity, and Inclusion	In establishing the Joint Working Arrangements, all partners acknowledge their requirements to exercise their obligations under the Agreement and consider how they can meet their legal duties to involve patients and the public in shaping the provision of services, including by working with local communities, under-represented groups, and those with protected characteristics for the purposes of the Equality Act 2010.	
Health inequalities	In establishing the Joint Working Arrangements, all partners acknowledge their requirements to exercise their obligations under the Agreement and consider how, in performing their obligations, they can address health inequalities	
Next Steps	Subject to approval by the Board, the Chief Executive/Assistant Chief executive will progress the work required to finalise and approve the Joint Working Agreement. Further details regarding Board member involvement in informing and agreeing the Joint Committee Terms of Reference will be communicated following the March meeting.	
Appendices	**Appendix One**	Specialised Commissioning Joint Committee Arrangements across England from April 2023
	Appendix Two	North West Specialised Commissioning Joint Working Agreement for 2023/24
	Appendix Three	FAQs for North West Specialised Commissioning Joint Working Arrangements
	Appendix Four	North West 'in scope' Specialised Commissioning Services

North West Specialised Commissioning Joint Working Agreement 2023 - 2024

1. Executive Summary

1.1 As reported to the Board at its February 2023 meeting, NHS England's (NHSE) board has approved plans to establish joint committees between NHS England and multi-ICB collaborations[1] from 01 April 2023 - covering nine geographical footprints (Appendix One) - that will oversee and take commissioning decisions on 59 specialised services within the portfolio. This will coincide with the introduction of population-based budgets for these services from April 2023, with the gradual and cautious application of a new needs weighted allocation formula from April 2024. Throughout 2023/24 the finances, liability and contracting will remain fully with NHS England albeit overseen by the joint committee.

1.2 A Joint Working Agreement (Appendix Two) and a set of accompanying FAQs (Appendix Three) has been developed to legally underpin the joint working model in 2023/24 for statutory joint committees between multi-ICBs and NHSE. These arrangements will be implemented using NHSE's powers under section 65Z5 of the NHS Act 2006. This model will:

- introduce a North West Specialised Services Committee (NWSSC) to facilitate collaboration and decision-making in relation to specialised services that have been determined by NHSE as suitable and ready for greater ICB involvement. The Joint Working Agreement includes a template Terms of Reference *(Schedule 2).* A process is underway to develop these Terms of Reference for the NWSSC and will be presented for agreement at the first meeting of that Committee. These will then be presented to a future meeting of each of the three ICB Boards for their approval.
- provide decision-making safeguards for NHSE, recognising that this is a transitional year and liability remains with NHSE
- support the managed transition to fully delegated commissioning arrangements for appropriate services in future
- allow the NWSSC to be consulted on specialised services that are being retained by NHS England, although it will not have any decision-making powers relating to these services

1.3 The arrangements in 2023/24 are intended to give ICBs greater involvement in the commissioning of Specialised Services to improve outcomes for people by better alignment and transformation of pathways of care supporting a focus on population health management, improving quality of services, and tackling health inequalities. It also provides the opportunity to develop relationships and ways of working before formally receiving delegation for 2024 onwards.

[1] https://www.england.nhs.uk/publication/nhs-england-public-board-meeting-agenda-and-papers-2-february-2023/

1.4 As has been highlighted previously with Board members, arrangements for 2024 onwards may require the ICB to have a number of differing Committee arrangements to discharge its specialised commissioning arrangements based on which services and functions the ICB undertakes on its own or jointly across possible differing geographies and partners (i.e., just cross Cheshire and Merseyside, across the North West or with other ICBs and NHSE teams on the borders with Cheshire and Merseyside). This is not within the scope of this paper but will need to be discussed and reported back to Board at a future meeting.

1.5 Additionally, commissioning responsibility for all other specialised services (outside of the 59) will be retained by NHSE in 2023/24. For some services, this will be on a permanent basis and for others this will be temporary and until the point that they are considered ready for delegation. The arrangements in 2023/24 represent a stepping-stone to delegating full commissioning responsibility for suitable services, including budgets and financial liability, to multi-ICB collaborations from April 2024. This will be subject to further NHS England Board consideration and decision.

2. Background

2.1 Specialised services are defined in legislation as services that meet at least one of three criteria:

- **Rarity** - the number of patients requiring the service
- **Scarcity** - limited availability of facilities or suitably qualified/experienced staff to safely provide a service
- **Cost** - unit cost of providing care is disproportionately high compared to other health services.

2.2 Specialised services often involve treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions. The nature of the services involves high costs, low volumes and are usually delivered in specialist centres of care where patient flows span ICB and multi-ICB geographies. Services are nationally prescribed to ensure specialist thresholds are met.

2.3 Since 2013, NHS England has been the accountable commissioner for the portfolio of 154 specialised services. These services are prescribed in regulations by the Secretary of State for Health and Social Care.

2.4 NHSE has developed list of specialised services that are suitable and ready for delegation to ICBs that are included within the scope of the Joint Working Agreement. Typically, for ICBs elsewhere in the country this will require all delegated services to be planned on a multi-ICB basis, however due to the large size of ICBs in the North West there is an opportunity for higher volume specialised services within the delegation list to be planned at a single ICB level.

2.5 ICBs in the North West have reviewed the list of 'in scope' services and agreed (at the North West Commissioning Integration Working Group on 29 September 2022) on those that are suitable for single ICB planning (and decision making) and those that will require collaboration and governance arrangements across all three North West ICBs. These are listed in Appendix Four.

2.6 The arrangements in 2023/24 are a transition to delegating full commissioning responsibility for suitable services, first set out in in the Roadmap for Integrating Specialised Services,[2] including budgets and financial liability, to multi-ICB collaborations from April 2024. This will be subject to further NHSE Board consideration and decision. Throughout 2023/24, the money, accountability and financial liability will remain fully with NHSE. Commissioning responsibility for all other specialised services will be retained by NHS England - for some services, this will be on a permanent basis and for others this will be temporary and until the point that they are considered ready for delegation.

3. Joint Working Agreement

3.1 To support establishment of joint commissioning arrangements, a template Joint Working Agreement (Appendix Two) has been made available for NHS England and ICBs. Development of the Joint Working Agreement has been coordinated by NHS England's national specialised commissioning strategy and policy team and the document has been drafted by legal services. It has involved extensive engagement and close collaboration with regional and national policy leads and subject matter experts.

3.2 Joint exercise of statutory functions will have an impact on decision-making, responsibilities, and resourcing. Appropriate governance arrangements are therefore required on finance responsibilities, contracting and the management and sharing of data. The Joint Working Agreement formalises these arrangements, detailing the roles and responsibilities of NHS England and ICBs where the statutory functions will be jointly exercised in line with the NHS Act 2006.

3.3 In addition to the general arrangements that will apply between NHS England and the ICBs in relation to the joint commissioning of specialised services for the ICBs' populations, there are nine further schedules covering:

- definitions and interpretations (Schedule 1)
- template terms of reference for a joint committee (Schedule 2)
- the list of services to be jointly exercised (Schedule 3)
- the list of functions to be jointly exercised (Schedule 4)
- the reserved (i.e., retained) services for NHS England (Schedule 5)
- the reserved (i.e., retained) functions for NHS England (Schedule 6)
- the scope for sharing information between NHS England the ICBs (Schedule 7)
- local terms for capture within the Agreement (Schedule 9).

[2] https://www.england.nhs.uk/wp-content/uploads/2022/05/PAR1440-specialised-commissioning-roadmap-addendum-may-2022.pdf

3.4 The completed Terms of Reference for the NWSSC are not required to be included in the Joint Working Agreement for it to be approved. Once the Terms of Reference has been approved then it will be included within the Joint Working Agreement but will also be published separately within the Corporate Governance Handbook on the ICB website.

3.5 The Joint Working Agreement needs to be signed by each partner organisation. It is recommended that the Assistant Chief Executive is the signatory for the ICB (which is consistent with the authority outlined within the ICB Scheme of Reservation and Delegation (Section 4.1).[3] **The Board is asked to approve this recommendation**.

3.6 Prior to receiving delegated arrangements from 01 April 2024, the Board will receive further detail around the delegation responsibilities. The ICB will also need to confirm which existing Committee will take on the responsibility of overseeing and approving decisions on specialised services for the Cheshire and Merseyside population alone, or establish a new Committee, as well as revisiting and agreeing the joint working agreement (and joint committee arrangements) for 2024/25 (and beyond) for those services required to be commissioned jointly (as identified in Appendix Four).

4. Legal Underpinning

4.1 Section 65Z5 of the NHS Act 2006 (inserted by the Health and Care Act 2022) permits NHS organisations to enter joint working and delegated arrangements in respect of their statutory functions, and this will be outlined within the Joint Working Agreement.

4.2 The NWSSC will be established pursuant to section 65Z6 of the NHS Act 2006 and is established so the joint working can be exercised through this body. Section 65Z6 also enables partners to establish a pooled fund, however for 2023/24 ICBs are not required to financially contribute to the Specialised Commissioning Budget and the Partners forming the NWSCC do not intend to create a pooled fund or joint budget for the purpose of the 2023/24 Agreement.

4.3 For the 2023/24 period, NHS England shall hold the Specialised Commissioning Budget and shall be responsible for paying for the Joint Specialised Services from the Specialised Commissioning Budget pursuant to the Specialised Services Contracts. NHS England will establish and maintain the financial and administrative support necessary to meet any auditing regulations applicable to NHS England.

4.4 Apart from what is set out in the Joint Working Agreement, the NWSSC does not affect the statutory responsibilities and accountabilities of the Partners.

[3] https://www.cheshireandmerseyside.nhs.uk/media/lxdfkwlk/cm-sord.pdf

5. Role of the NWSSC

5.1 The role of the NWSSC during 2023/24 will focus on:

- making decisions about the North West population across whole pathways of care within a framework of nationally set standards and access to technology
- supporting the move from provider based to population-based budgets, so that the funding approach for specialised services are aligned with those for other NHS services.
- the oversight of clinical leadership and clinical risk management of specialised services
- jointly managing and commissioning clinical networks.
- maintaining specialised commissioning expertise and the development of a workforce model to maintain a protected concentration of specialised commissioning capacity and capability, ensuring the most appropriate workforce model is in place to support delegated commissioning arrangements from 01 April 2024
- the development of a specialised commissioning delivery plan as set out in the 2023/24 NHS Operational Planning Guidance[4] to '*identify at least three key priority pathways for transformation, where integrated commissioning can support the triple aim of improving quality of care, reducing inequalities across communities, and delivering best value.'*

5.2 The NWSSC will be a formal decision-making Committee of the ICB. It is an important distinction to note that whilst its membership will be drawn from representatives of all three North West ICBs and NHSE, each individual will be a member of the Committee and the NWSSC will be acting and making decisions on behalf of and in the interests of all four partners, not just their individual employing organisations. Members will be there making decisions on behalf of the North Wes population. Whilst NHSE continues to reserve the liability, responsibility and accountability for the joint functions, arrangements and decisions will need to be in a manner as to ensure NHSE compliance with NHSE's statutory duties in respect of the Joint Functions and to enable NHSE to fulfil its Reserved Functions.

5.3 As outlined within the Agreement and Terms of Reference, the NWSSC must reach decisions in relation to the joint functions through discussion and agreement. Where in exceptional cases consensus cannot be reached between members of the NWSCC the voting arrangements set out in the approved Terms of Reference will apply.

5.4 It should also be noted that NHSE reserve the right to exercise the Joint Functions outside of the Joint Working Arrangements where, in its view, it is necessary for reasons of urgency. In such circumstances it shall inform the Partners of such action at the earliest reasonable opportunity.

[4] https://www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/

6. NWSCC Terms of Reference

6.1 The template draft Terms of Reference has been included within Appendix Two (Schedule Two). It is recognised by all three North West ICBs and NHSE that further work is required to agree these Terms of Reference and further engagement sessions with ICB Board members are being planned. Further details about this will be communicated to the Board.

6.2 Whilst the completed Terms of Reference are not required to be included in the Joint Working Agreement when this approved, they will need to be agreed at the first meeting of the NWSSC and then approval sought from each partner Body before the Committee is formally established.

6.3 There are several provisions and guidance notes enabling NHSE regions and ICBs to adapt the Terms of Reference to meet local arrangements. Within Schedule Two of Appendix Two there are currently proposed revisions highlighted in **BLUE** that have been agreed by the NHSE North West Specialised Commissioning team and ICB leads, and the text highlighted in **YELLOW** indicates information that still needs to be agreed and included by partners.

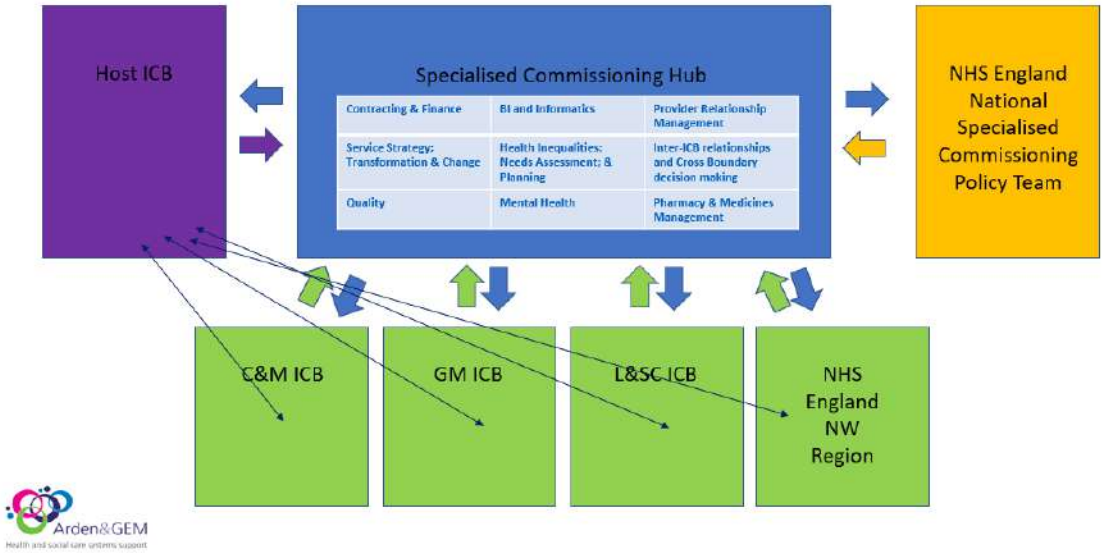
6.4 Key areas still to be determined include:

- identification of the Cheshire and Merseyside ICB authorised officer on the NWSSC who will carry voting rights. **It is recommended that the Assistant Chief Executive is the nominated officer for the ICB. The Board is asked to approve this recommendation.**
- identification of a representative from NHS Cheshire and Merseyside ICB who will act in an independent member role on the NWSSC. This individual will not have a voting right but provide additional accountability and assurance around decision-making in line with the Partners' statutory duties.
- decisions and voting arrangements. There are three options outlined within draft Terms of Reference that outline the voting arrangement required for a decision if a decision cannot be reached by consensus.

7. Readiness to operate under full delegation from April 2024 – due diligence process

7.1 Nationally it has been determined that the operating model for delegation in 2024 and beyond will require each region to identify an ICB to host the Specialised Commissioning Team in its area. In the North West, an agreement in principle has been made that the regional Specialised Commissioning 'Hub' team will be hosted by NHS Lancashire and South Cumbria ICB from 1 April 2024. Diagram One provides an outline of the proposed operational structure.

Diagram One: Proposed North West Operating Model



7.2 Throughout 2023 further work will continue with NHSE and the two other North West ICBs in developing the operating model as well as finalising the Pre-Delegation Assessment Framework (PDAF) so as to provide the necessary assurance to NHSE that the ICB can safely receive full delegation of specialised services (in scope for ICBs) from 1 April 2024.

7.3 A working group has been established with NHSE regional colleagues and the two other North West ICBs, and which meets on a two-weekly basis. Its primary aim is to oversee the programme plan for delegation of specialised services and to escalate any anticipated delays or overdue actions. Progress updates will be provided to the Board throughout the year via the reports of the NWSSC.

8. Recommendations

8.1 The Board is asked to:

- **note** the contents of the report the list of services in the North West that are appropriate for greater ICB leadership from April 2023, those that are likely to be appropriate at a future point in time, and those services where commissioning responsibility will be retained by NHSE
- **approve** the ICB entering into a Joint Working Agreement and progressing the work to establish statutory joint committee arrangements with NHS England and NHS Greater Manchester and NHS Lancashire and South Cumbria ICBs for the 2023/24 period
- **approve** delegating authority to the Assistant Chief Executive to sign the Joint Working Agreement on behalf of NHS Cheshire and Merseyside to enable these commissioning arrangements to ‘go live’ from April 2023
- **note** that further engagement will be undertaken with members of the three ICB Boards in developing and agreeing the Joint Committee Terms of Reference.

9. Next Steps

8.1 Subject to approval by the Board, the Chief Executive/Assistant Chief Executive will progress the work required to finalise and approve the Joint Working Agreement.

9.2 Further details regarding Board member involvement in informing and agreeing the NWSSC Terms of Reference will be communicated following the March meeting.

10. Officer Contact details for more information

Clare Watson
Assistant Chief Executive
clare.watson@cheshireandmerseyside.nhs.uk

NHS Cheshire and Merseyside Integrated Care Board Meeting

North West Specialised Commissioning Joint Working Agreement 2023 - 2024

Appendix One: Joint Committees Map

Proposed Joint Committees

Discussions remain ongoing and these proposals may be subject to change, with some regions considering sub-committees based on geographies or services.

~ 90% of core service spend is planned for greater ICB leadership[3]

North East North Cumbria	
Population footprint[1]	3,008,913
22/23 Baseline allocation[2] (£)	530,756,150

Yorkshire and the Humber	
Population footprint[1]	5,526,350
22/23 Baseline allocation[2] (£)	977,217,204

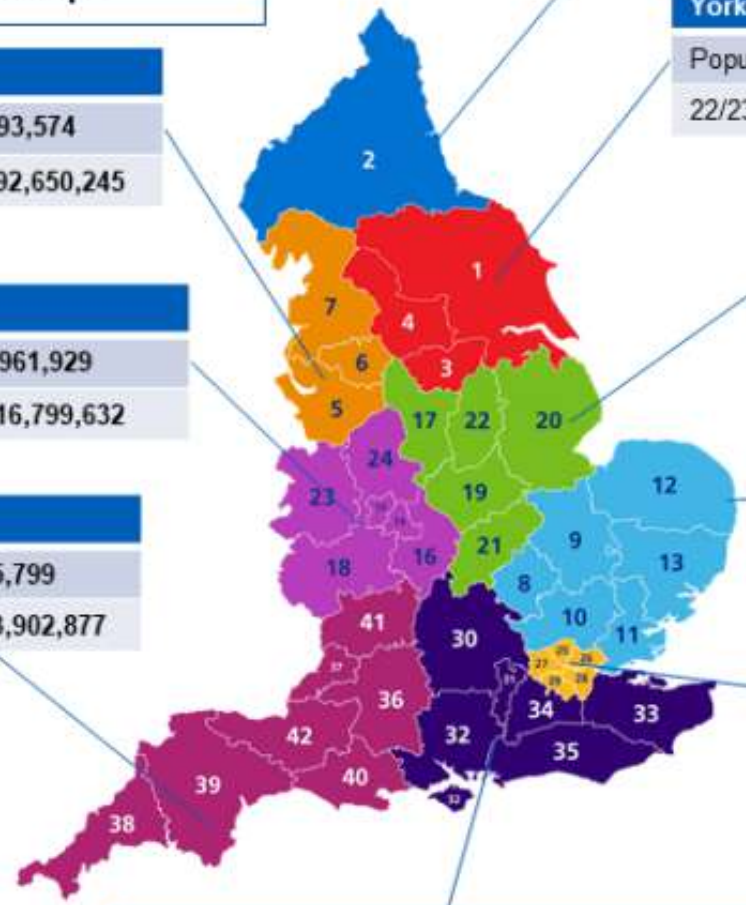
North West	
Population footprint[1]	7,693,574
22/23 Baseline allocation[2] (£)	1,592,650,245

East Midlands	
Population footprint[1]	4,696,629
22/23 Baseline allocation[2] (£)	915,007,681

West Midlands	
Population footprint[1]	5,961,929
22/23 Baseline allocation[2] (£)	1,216,799,632

East of England	
Population footprint[1]	7,082,155
22/23 Baseline allocation[2] (£)	1,248,453,788

South West	
Population footprint[1]	5,665,799
22/23 Baseline allocation[2] (£)	1,093,902,877



London	
Population footprint[1]	10,579,509
22/23 Baseline allocation[2] (£)	2,295,275,813

South East	
Population footprint[1]	9,185,122
22/23 Baseline allocation[2] (£)	1,729,451,243

Services that are suitable but not yet ready for greater ICB leadership in 23/24[4]	
22/23 Baseline allocation (£)	1,552,218,137

These services will form part of discussions at Joint Committees, however ICBs will not have shared decision-making responsibilities and voting rights for them.

1. Population footprints used on this slide were provided by regions in their summaries or entered nationally where they were not provided. As a result, several different data sources have been used.

2. As the 23/24 allocations are not yet available, these figures are the 22/23 indicative baseline population based allocations for acute and mental health services that are suitable and ready for greater ICB leadership in 23/24.

3. This includes both services that are suitable and ready; and services that are suitable but not yet ready (with the exception of services that are in scope of Mental Health, Learning Disability and Autism Provider Collaboratives).

4. Please note this does not include services that are in scope of Mental Health, Learning Disability and Autism Provider Collaboratives.

NHS Cheshire and Merseyside Integrated Care Board Meeting

North West Specialised Commissioning Joint Working Agreement 2023 - 2024

Appendix Two: Joint Working Agreement

Dated 2023

(1) **NHS ENGLAND**

- and -

(2) **NHS CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD**

- and -

(3) **NHS GREATER MANCHESTER INTEGRATED CARE BOARD**

- and -

(4) **NHS LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE BOARD**

Agreement in relation to the establishment and operation of joint working arrangements

[NOTE: This draft Joint Working Agreement is for use between NHS England and ICBs in relation to the establishment of joint working arrangements for Specialised Commissioning.]

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THIS AGREEMENT is made on the_____ day of _____2023

BETWEEN[1]**:**

(1) **NHS England** of Quarry House, Quarry Hill, Leeds LS2 7UE (acting under the name NHS England) ("**NHS England"**); and

(2) **NHS Cheshire and Merseyside Integrated Care Board** of Regatta Place, Brunswick Business Park, Liverpool, L3 4BL (" NHS Cheshire and Merseyside ICB");

(3) **NHS Greater Manchester Integrated Care Board** of 3 Piccadilly Place, Manchester, M1 3BN ("NHS Greater Manchester ICB"); and

(4) **NHS Lancashire and South Cumbria Integrated Care Board** of Chorley House, Lancashire Enterprise Business Park, Centurion Way, Leyland, Lancashire, PR26 6TT ("NHS Lancashire and South Cumbria ICB**"**).

each a "Partner" and together the "Partners".

NHS Cheshire and Merseyside **ICB**, NHS Greater Manchester **ICB** and NHS Lancashire and South Cumbria **ICB** are together referred to in this Agreement as the **"ICBs",** and **"ICB"** shall mean any of them.

BACKGROUND

(A) NHS England has statutory functions to make arrangements for the provision of prescribed services for the purposes of the NHS.

(B) The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their areas, apart from those commissioned by NHS England.

(C) Pursuant to section 65Z5 of the NHS Act, NHS England and the ICBs are able to establish and maintain joint arrangements in respect of the discharge of their commissioning functions.

(D) NHS England and the ICBs agree to jointly exercise the Joint Functions through the decisions of the Joint Committee under section 65Z5 of the NHS Act and as set out in this Agreement and the Terms of Reference.

(E) NHS England and the ICBs acknowledge and agree that making arrangements to involve the ICBs in the exercise of NHS England's Commissioning Functions is likely to lead to an improvement in the way the Commissioning Functions of all Partners are exercised.

(F) This Agreement sets out the arrangements that will apply between NHS England and the ICBs in relation to the joint commissioning of Specialised Services for the ICBs' Populations. These arrangements are intended to give the ICBs greater involvement in the commissioning of Specialised Services to better align and transform pathways of care around the needs of local populations.

(G) NHS England and the ICBs have entered into this Agreement to define their arrangements for joint working. To avoid doubt, none of the Partners are delegating the exercise of any of their Commissioning Functions or any other functions to any other Partner under this Agreement.

(H) This Agreement is intended for use in the 2023/24 financial year, to govern what are envisaged to be transitional joint working arrangements prior to the delegation of specialised commissioning functions from NHS England to ICBs, effective from 2024.

[1] Complete Partners' names as appropriate.

NOW IT IS HEREBY AGREED as follows:

1. **COMMENCEMENT AND DURATION**

1.1 This Agreement has effect from the date of this Agreement and will remain in force for the Initial Term unless terminated in accordance with Clause 20 (Leaving the Joint Committee) below.

1.2 The Partners may extend this Agreement beyond the Initial Term for a further period, by written agreement prior to the expiry of the Initial Term.

2. **PRINCIPLES AND AIMS**

2.1 The Partners acknowledge that, in exercising their obligations under this Agreement, each Partner must comply with the statutory duties set out in the NHS Act and must:

2.1.1 consider how it can meet its legal duties to involve patients and the public in shaping the provision of services, including by working with local communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010;

2.1.2 consider how, in performing its obligations, it can address health inequalities;

2.1.3 at all times exercise functions effectively, efficiently and economically; and

2.1.4 act at all times in good faith towards each other.

2.2 The Partners agree:

2.2.1 that successfully implementing this Agreement will require strong relationships and an environment based on trust and collaboration;

2.2.2 to seek to continually improve whole pathways of care including Specialised Services and to design and implement effective and efficient integration;

2.2.3 to act in a timely manner;

2.2.4 to share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risks and reduce cost;

2.2.5 to act at all times in accordance with the scope of their statutory powers; and

2.2.6 to have regard to each other's needs and views, irrespective of the relative contributions of the Partners to the commissioning of any Specialised Services and, as far as is reasonably practicable, take such needs and views into account.

2.3 The Partners' primary aim is to maximise the benefits to patients of integrating the Joint Functions with the ICBs' Commissioning Functions through designing and commissioning the Joint Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

3. SCOPE OF JOINT WORKING ARRANGEMENTS

3.1 This Agreement sets out the arrangements through which the Partners will work together to exercise the Joint Functions as set out in Schedule 4, including:

3.1.1 the establishment of a Joint Committee;

3.1.2 the participation by all Partners in the work of the Joint Committee;

3.1.3 the development of leadership and expertise in respect of the Joint Specialised Services;

collectively referred to as the "Joint Working Arrangements".

4. JOINT COMMITTEE

4.1 NHS England shall together with the ICBs establish a Joint Committee which will operate in accordance with the Terms of Reference set out in Schedule 2 (Joint Committee – Terms of Reference). The Joint Committee (and each member of the Joint Committee) will act at all times in accordance with the Terms of Reference.

4.2 The Partners shall nominate Authorised Officers to the Joint Committee in accordance with Schedule 2.

4.3 Subject to Clauses 4.4 and 8.1 and the terms of the Schedules, NHS England shall exercise the Joint Functions collaboratively with the ICBs in accordance with this Agreement and must reach decisions in relation to the Joint Functions through discussion and agreement. Where in exceptional cases consensus cannot be reached between the members of the Joint Committee in respect of matters under consideration, the voting arrangements set out in the Terms of Reference will apply.

4.4 NHS England may at any time exercise the Joint Functions outside of the Joint Working Arrangements where, in its view, that is necessary for reasons of urgency, and in such circumstances it shall inform the Partners of such action at the earliest reasonable opportunity.

4.5 The Partners may establish sub-groups or sub-committees of the Joint Committee with such terms of reference as may be agreed between them from time to time. Any such sub-groups or sub-committees that are in place at the commencement of this Agreement may be documented in the Local Terms (Schedule 9).

4.6 The ICBs shall ensure that their Authorised Officers have appropriate delegated authority, in accordance with each ICB's internal governance arrangements, to represent the interests of each ICB in the Joint Committee and any other sub-groups or sub-committees established by the Joint Committee.

4.7 The Partners recognise the need to ensure that any potential conflicts of interest on the part of any Partner, including its representatives, in respect of this Agreement and the establishment or operation of the Joint Committee and any sub-group or sub-committee of the Joint Committee must be appropriately identified, recorded and managed.

5. JOINT FUNCTIONS

5.1 This Agreement shall include such Joint Functions as identified in Schedule 4 in respect of the Joint Specialised Services.

5.2 The Joint Committee must establish effective, safe, efficient and economic arrangements for the discharge of the Joint Functions.

5.3 The Joint Committee must exercise the Joint Functions in accordance with:

5.3.1 the terms of this Agreement;

5.3.2 all applicable Law;

5.3.3 Guidance;

5.3.4 the Terms of Reference; and

5.3.5 Good Practice.

5.4 In exercising the Joint Functions, the Joint Committee must comply with the Mandated Guidance set out in Schedule 8, or otherwise referred to in this Agreement, and such further Mandated Guidance as may be issued by NHS England from time to time, including on the NHS England or FutureNHS websites.

5.5 The Joint Committee must perform the Joint Functions:

5.5.1 in such a manner as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Joint Functions and to enable NHS England to fulfil its Reserved Functions; and

5.5.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Joint Functions and Reserved Functions.

6. THE RESERVED FUNCTIONS

6.1 NHS England will exercise the Reserved Functions, including but not limited to those set out in Schedules 5 (Retained Services) and 6 (Reserved Functions).

6.2 The Reserved Functions include all of NHS England's Specialised Commissioning Functions other than the Joint Functions.

6.3 The Partners acknowledge that NHS England may ask the ICBs to provide certain administrative and management services to NHS England in relation to Reserved Functions.

7. FURTHER COLLABORATIVE WORKING

7.1 An ICB may, at its discretion, table for discussion at any Joint Committee meeting an item relating to any ICB Function, where such ICB Function relates to Specialised Commissioning Functions, in order to facilitate engagement and promote integration and collaborative working. Decision-making in respect of such discussions will remain with the relevant ICB. For the avoidance of doubt, the Joint Committee will not have any authority to take decisions in respect of ICB Functions.

7.2 NHS England may, at its discretion, table for discussion at any Joint Committee meeting an item relating to a Reserved Function (including but not limited to the Part A Retained Services) or any such other of NHS England's Functions that it considers appropriate in order to facilitate engagement and promote integration and collaborative working. For the avoidance of doubt, the Joint Committee will only have authority to take decisions in respect of the Joint Functions. The decision-making will remain with NHS England for all other NHS England Functions.

8. **FINANCE**

8.1 For the Initial Term, NHS England shall hold the Specialised Commissioning Budget and shall be responsible for paying for the Joint Specialised Services from the Specialised Commissioning Budget pursuant to the Specialised Services Contracts. NHS England will establish and maintain the financial and administrative support necessary to meet any auditing regulations applicable to NHS England. The Joint Committee shall ensure full compliance with the Finance Guidance and any other relevant Mandated Guidance.

8.2 For the avoidance of doubt, in the Initial Term, the ICBs are not required to financially contribute to the Specialised Commissioning Budget and the Partners do not intend to create a pooled fund or joint budget for the purpose of this Agreement. The NHS England Standing Financial Instructions shall apply in respect to the commissioning of all Joint Specialised Services.

8.3 Each Partner shall bear its own costs as they are incurred, unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by the Partners. Such costs may include, but will not be limited to, costs of attendance at Joint Committee meetings and costs in complying with each Partner's relevant obligations in this Agreement.

8.4 Prior to the end of the first year of the Term, the Partners will review the financial arrangements described in this Clause 8 (Finance) and consider whether alternative arrangements should be put in place for any extended Term. Any changes to this Agreement to effect such new arrangements will be made in accordance with Clause 10 (Variations).

9. **STAFFING**

9.1 During the Initial Term the Specialised Services Staff shall be employed by NHS England.

9.2 The Partners must comply with any Mandated Guidance issued by NHS England from time to time in relation to any NHS England Staff.

10. **VARIATIONS**

10.1 The Partners acknowledge that the scope of the Joint Working Arrangements, including the scope of the Joint Functions, may be reviewed and amended from time to time.

10.2 This Agreement may be varied by the agreement of the Partners at any time in writing in accordance with the Partners' internal decision-making processes.

11. **DATA PROTECTION**

11.1 The Partners must ensure that all Personal Data processed by or on behalf of them in the course of carrying out the Joint Working Arrangements is processed in accordance with the relevant Partner's obligations under Data Protection Legislation and Data Guidance, and the Partners must assist each other as necessary to enable each other to comply with these obligations.

11.2 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis. If any Partner:

11.2.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

11.2.2 becomes aware of any security breach,

in respect of the Relevant Information it shall promptly notify the Joint Committee and NHS England. The Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable.

11.3 In processing any Relevant Information further to this Agreement, each Partner shall at all times comply with all NHS England policies and guidance on the handling of data.

11.4 Any information governance breach must be responded to in accordance with Data Security and the Protection Incident Reporting tool. If any Partner is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach, then, as soon as reasonably practical and in any event on or before the first such notification is made, the relevant Partner must fully inform NHS England and the Joint Committee of the information governance breach. This clause does not require the relevant Partner to provide information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

11.5 Whether or not a Partner is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Partners acknowledge that a Partner may act as both a Data Controller and a Data Processor.

11.6 The Partners will share information to enable joint service planning, commissioning, and financial management subject to the requirements of law, including in particular the Data Protection Legislation in respect of any Personal Data.

11.7 Other than in compliance with judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise required by any Law, no information will be shared with any other Partners save as agreed by the Partners in writing.

11.8 Schedule 7 makes further provision about information sharing and information governance.

12. IT INTER-OPERABILITY

12.1 The Partners will work together to ensure that all relevant IT systems operated by the Partners in respect of the Joint Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

12.2 The Partners will use their respective reasonable endeavours to help develop initiatives to further this aim.

13. FURTHER ARRANGEMENTS

13.1 The Partners must give due consideration to whether any of the Joint Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act. The Partners must comply with any Guidance around the commissioning of Joint Specialised Services by means of arrangements under section 65Z5 or 75 of the NHS Act.

14. **FREEDOM OF INFORMATION**

14.1 Each Partner acknowledges that the others are a public authority for the purposes of the Freedom of Information Act 2000 (**"FOIA"**) and the Environmental Information Regulations 2004 (**"EIR"**).

14.2 Each Partner may be statutorily required to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

14.2.1 each Partner shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

14.2.2 each Partner shall consult the other regarding the possible application of exemptions in relation to the information requested; and

14.2.3 each Partner acknowledges that the final decision as to the form or content of the response to any request is a matter for the Partner to whom the request is addressed.

14.3 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to of FOIA or EIR requests in relation to the Joint Working Arrangements. The Joint Committee and each Partner shall comply with such FOIA or EIR protocols.

15. **CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY**

15.1 The Partners must and must ensure that, in delivering the Joint Functions, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

15.2 Without prejudice to the general obligations set out in Clause 5 (Joint Functions), each ICB must maintain a register of interests in respect of all persons involved in decisions concerning the Joint Functions. This register must be publicly available. For the purposes of this clause, an ICB may rely on an existing register of interests rather than creating a further register.

15.3 Where any member of the Joint Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Joint Committee, that member must not participate in meetings (or parts of meetings) in which the relevant matter is discussed or make a recommendation in relation to the relevant matter. The relevant appointing body may send an alternative representative to take the place of the conflicted member in relation to that matter.

16. **CONFIDENTIALITY**

16.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Partner and the receiving Partner has no right to use it.

16.2 Subject to Clause 16.3, the receiving Partner agrees:

16.2.1 to use the disclosing Partner's Confidential Information only in connection with the receiving Partner's performance under this Agreement;

16.2.2 not to disclose the disclosing Partner's Confidential Information to any third party or to use it to the detriment of the disclosing Partner; and

16.2.3 to maintain the confidentiality of the disclosing Partner's Confidential Information.

16.3 The receiving Partner may disclose the disclosing Partner's Confidential Information:

16.3.1 in connection with any Dispute Resolution Procedure;

16.3.2 to comply with the Law;

16.3.3 to any appropriate Regulatory or Supervisory Body;

16.3.4 to its staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Partner's duty under Clause 16.2;

16.3.5 to NHS Bodies for the purposes of carrying out their functions;

16.3.6 as permitted under any other express arrangement or other provision of this Agreement.

16.4 The obligations in Clause 16 will not apply to any Confidential Information which:

16.4.1 is in or comes into the public domain other than by breach of this Agreement;

16.4.2 the receiving Partner can show by its records was in its possession before it received it from the disclosing Party; or

16.4.3 the receiving Partner can prove it obtained or was able to obtain from a source other than the disclosing Partner without breaching any obligation of confidence.

16.5 This Clause 16 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by an ICB where necessary for the purposes of exercising its functions in relation to that ICB.

16.6 This Clause 16 will survive the termination of this Agreement for any reason for a period of 5 years.

16.7 This Clause 16 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

17. LIABILITIES

17.1 Nothing in this Agreement shall affect:

17.1.1 the liability of NHS England to any person in respect of NHS England's Commissioning Functions; or

17.1.2 the liability of any of the ICBs to any person in respect of that ICB's Commissioning Functions.

17.2 NHS England shall be responsible for and shall retain the conduct of any Claim in relation to the Joint Functions and Reserved Functions.

17.3 Each ICB must:

17.3.1 comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims or the pro-active management of Claims;

17.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence;

17.3.3 co-operate fully with NHS England in relation to such Claim and the conduct of such Claim;

17.3.4 provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim; and/or

17.3.5 at the request of NHS England, take such action or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

18. DISPUTE RESOLUTION

18.1 Where any dispute arises within the Joint Committee in connection with this Agreement, the Partners must use their best endeavours to resolve that dispute within the Joint Committee in accordance with the Terms of Reference.

18.2 Where any dispute is not resolved under Clause 18.1 on an informal basis, any Authorised Officer may convene a special meeting of the Joint Committee to attempt to resolve the dispute.

19. BREACHES OF THE JOINT WORKING AGREEMENT

19.1 If any Partner does not comply with the terms of this Agreement, then NHS England may:

19.1.1 exercise its rights under this Agreement; and

19.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the Partner.

19.2 Without prejudice to Clause 19.1, if any Partner does not comply with the terms of this Agreement (including if the Joint Committee or any Partner exceeds its authority under this Agreement), NHS England may (at its sole discretion):

19.2.1 waive its rights in relation to such non-compliance in accordance with Clause 19.3;

19.2.2 ratify any decision;

19.2.3 terminate this Agreement in accordance with Clause 20 (Leaving the Joint Committee*)* below;

19.2.4 exercise the dispute resolution procedure in accordance with Clause 18 *(Dispute Resolution Procedure)*; and/or

19.2.5 exercise its rights under common law.

19.3 NHS England may waive any non-compliance by a Partner with the terms of this Agreement provided that the Partner provides a written report to the Joint Committee as required by Clause 19.4 and, after considering the Partner's written report, NHS England is satisfied that the waiver is justified.

19.4 If:

19.4.1 a Partner does not comply with this Agreement; or

19.4.2 NHS England notifies a Partner that it considers the Partner has not complied, or may not be able to comply with, this Agreement;

then that Partner must provide a written report to the NHS England within ten (10) Operational Days of the non-compliance (or the date on which the relevant Partner considers that it may not be able to comply with this Agreement) or such notification pursuant to Clause 25 setting out:

19.4.3 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement; and

19.4.4 if the non-compliance is capable of remedy, a plan for how the Partner proposes to remedy the non-compliance.

20. LEAVING THE JOINT COMMITTEE

20.1 If an ICB wishes to exit the Joint Committee and end its participation in this Agreement, the relevant ICB must provide at least six (6) months' notice to NHS England of its intention to exit the Joint Committee and end its participation in this Agreement. Such notification shall only take effect from the end of 31 March in any calendar year.

20.2 NHS England and the ICBs will work together to ensure that there are suitable alternative arrangements in place in relation to the exercise of the Joint Functions.

20.3 The ICB(s) acknowledge that the exercise of the Joint Functions remains the responsibility of NHS England.

20.4 NHS England may terminate this Agreement forthwith where it considers it necessary or expedient to terminate the Joint Working Arrangements, but in reserving this power NHS England anticipates that this will only be used in exceptional circumstances and that in all instances it will use its reasonable endeavours to seek an orderly termination of the Joint Working Arrangements.

21. CONSEQUENCES OF TERMINATION

21.1 Upon termination of this Agreement (in whole or in part), for any reason whatsoever, the following shall apply:

21.1.1 the Partners agree that they will work together and co-operate to ensure that the winding down of these arrangements is carried out smoothly and with as little disruption as possible to patients, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

21.1.2 termination of this Agreement shall have no effect on the liability of any rights or remedies of any Partner already accrued, prior to the date upon which such termination takes effect.

21.2 The provisions of Clauses 11 (Data Protection), 14 (Freedom of Information), 16 (Confidentiality), 17 (Liabilities) and 21 (Consequences of Termination) shall survive termination or expiry of this Agreement.

22. PUBLICITY

22.1 The Partners shall use reasonable endeavours to consult one another before making any public announcements concerning the subject matter of this Agreement.

23. EXCLUSION OF PARTNERSHIP OR AGENCY

23.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Partners, or render any Partner directly liable to any third party for the debts, liabilities or obligations of any Partner.

23.2 Save as specifically authorised under the terms of this Agreement, no Partner shall hold itself out as the agent of any other Partner.

24. THIRD PARTY RIGHTS

24.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Partners to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

25. NOTICES

25.1 Any notices given under this Agreement must be sent by e-mail to the relevant Authorised Officers or their nominated deputies.

25.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

26. ASSIGNMENT AND SUBCONTRACTING

26.1 This Agreement, and any right and conditions contained in it, may not be assigned or transferred by a Partner, without the prior written consent of the other Partners, except to any statutory successor to the relevant function.

27. SEVERABILITY

27.1 If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

28. WAIVER

28.1 No failure or delay by a Partner to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

29. STATUS

29.1 The Partners acknowledge that they are health service bodies for the purposes of section 9 of the NHS Act. Accordingly, this Agreement shall be treated as an NHS contract and shall not be legally enforceable.

30. **ENTIRE AGREEMENT**

30.1 This Agreement constitutes the entire agreement and understanding of the Partners and supersedes any previous agreement between the Partners relating to the subject matter of this Agreement.

31. **GOVERNING LAW AND JURISDICTION**

31.1 Subject to the provisions of Clause 18 (Dispute Resolution) and Clause 29 (Status), this Agreement shall be governed by and construed in accordance with English Law, and the Partners irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

32. **FAIR DEALINGS**

32.1 The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that, if in the course of the performance of this Agreement, unfairness to either of them does or may result, then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

33. **COMPLAINTS**

33.1 Any complaints received by the Partners shall be dealt with in accordance with the statutory complaints procedure of the Partner to whose Commissioning Function(s) the complaint relates. For the avoidance of doubt, NHS England shall manage all complaints in respect of the Joint Specialised Services and Retained Services.

34. **COUNTERPARTS**

34.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

This Agreement has been entered into on the date stated at the beginning of it.

SIGNED by ....

for and on behalf of NHS England (Signature)

.....

(Date)

SIGNED by Clare Watson, Assistant Chief Executive .....

for and on behalf of NHS Cheshire and Merseyside Integrated Care Board (Signature)

.....

(Date)

SIGNED by Sarah Price, Chief Officer for Population Health and Inequalities and Deputy Chief Executive .....

(Signature)

for and on behalf of NHS Greater Manchester Integrated Care Board

.....

(Date)

SIGNED by Professor Craig Harris, Chief of Health and Care Integration / Kevin Lavery, Chief Executive .....

(Signature)

for and on behalf of NHS Lancashire and South Cumbria Integrated Care Board

.....

(Date)

SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS

DEFINITIONS AND INTERPRETATION

1. In this Agreement, unless the context otherwise requires, the following words and expressions shall have the following meanings:

“Agreement"	this agreement between the Partners comprising these terms and conditions together with all schedules attached to it;
“Area”	means the geographical area covered by the ICBs;
“Assurance Processes”	has the meaning in Paragraph 8 of Schedule 4 (Oversight and Assurance);
"Authorised Officer"	the individual(s) appointed as Authorised Officer in accordance with Schedule 2 (Terms of Reference);
"Change in Law"	a change in Law that is relevant to the arrangements made under this Agreement, which comes into force after the Commencement Date;
“Claim”	means for or in relation to the Joint Functions and Reserved Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by any governmental, regulatory or similar body or agency;
“Clinical Commissioning Policies”	a nationally determined clinical policy sets out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service;
“Clinical Reference Groups”	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
“Collaborative Commissioning Agreement”	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
"Commencement Date"	means 1 April 2023;
"Commissioning Functions"	the respective statutory functions of the Partners in arranging for the provision of services as part of the health service;
"Confidential Information"	means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement or arrangements made pursuant to it and: (a) which comprises Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner; or

(c) which is a trade secret;

"Contracting Standard Operating Procedure"	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Joint Specialised Services;
"Core Membership"	means the voting membership of the Joint Committee as set out in the Terms of Reference;
"Data Controller"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Processor"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
"Data Protection Legislation"	means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of personal data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;
"Data Protection Officer"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Security and Protection Incident Reporting tool"	the incident reporting tool for data security and protection incidents, which forms part of the Data Security and Protection Toolkit available at https://www.dsptoolkit.nhs.uk/;
"**Delegated Commissioning Group**" **"DCG"**	means a group hosted by NHS England whose terms shall include providing an assurance role in compliance with the Assurance Processes;
"Dispute Resolution Procedure"	the procedure set out in Clause 18 (Dispute Resolution);
"Finance Guidance"	guidance, rules and operating procedures produced by NHS England that relate to these Joint Working Arrangements, including but not limited to the following:

- Commissioning Change Management Business Rules;

- Contracting Standard Operating Procedure;
- Cashflow Standard Operating Procedure;
- Finance and Accounting Standard Operating Procedure;
- Service Level Framework Guidance;

"FOIA"	the Freedom of Information Act 2000 and any subordinate legislation made under it from time to time, together with any guidance or codes of practice issued by the Information Commissioner or relevant government department concerning this legislation;
"Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Partners have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified by any relevant Regulatory or Supervisory Body;
"High Cost Drugs"	Means medicines not reimbursed though national prices and identified on the NHS England high cost drugs list;
"ICB Functions"	the Commissioning Functions of the ICB;
"Information"	has the meaning given under section 84 of FOIA;
"Indemnity Arrangement"	mean either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
"Information Sharing Agreement"	any information sharing agreement entered into in accordance with Schedule 7 (Further Information Governance and Sharing Provisions);
"Indemnity Arrangement"	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
"Initial Term"	the period of one year from 1 April 2023;
"Joint Committee"	means the joint committee of NHS England and the ICBs, established under this Agreement on the terms set out in the Terms of Reference;
"Joint Working Arrangements"	means the arrangements for joint working as set out in Clause 3 (Scope of Joint Working Arrangements);
"Joint Functions"	those aspects of the NHS England Specialised Commissioning Functions, as set out in Schedule 4, that shall be jointly exercised by NHS England and the ICBs through the decisions of the Joint Committee in accordance with the Terms of Reference;
"Joint Specialised Services"	means those Specialised Services listed in Schedule 3 (Joint Specialised Services);
"Law"	means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(c) any judgment of a relevant court of law which is a binding precedent in England;

"Mandated Guidance" means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Joint Functions and issued by NHS England from time to time as mandatory in respect of the Joint Working Arrangements. At the Commencement Date the Mandated Guidance in respect of the Joint Functions shall be as set out in Schedule 8;

"National Standards" means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;

"National Specifications" the service specifications published by NHS England in respect of Specialised Services;

"Need to Know" has the meaning set out in Schedule 7;

"NHS Act" the National Health Service Act 2006;

"NHS England Functions" NHS England's statutory functions exercisable under or by virtue of the NHS Act;

"Non-Personal Data" means data which is not Personal Data;

"**Oversight Framework**" means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHS England;

"Part A Retained Services" means those services listed in Part A of Schedule 5;

"Part B Retained Services" means those services listed in Part B of Schedule 5;

"Partners" the parties to this Agreement;

"Personal Data" has the meaning set out in the Data Protection Legislation;

"Population" means the population for which an ICB or all of the ICBs have the responsibility for commissioning health services;

"Provider Collaborative" a group of Specialised Service Providers who have agreed to work together to improve the care pathway for one or more Specialised Services;

"Provider Collaborative Arrangements"	Means the contracting arrangements entered into in respect of a Provider Collaborative;
"Provider Collaborative Guidance"	Means the guidance published by NHS England in respect of Provider Collaboratives;
"Regional Quality Group"	A group set up to act as a strategic forum at which regional partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
"Regulatory or Supervisory Body"	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) NICE; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;
"Relevant Information"	means the Personal Data and Non-Personal Data processed under this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
"Request for Information"	has the meaning set out in the FOIA;
"Reserved Functions"	those aspects of the Specialised Commissioning Functions that are not Joint Functions, including but not limited to those set out in Schedule 6;
"**Relevant Clinical Networks"**	means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
"Retained Services"	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out in Schedule 5 and being the Part A Retained Services and the Part B Retained Services;

“Shared Care Arrangements”	these arrangements support patients receiving elements of their care closer to home, whilst still ensuring that they have access to the expertise of a specialised centre and that care is delivered in line with the expectation of the relevant National Specification;
“Single Point of Contact”	the member of Staff appointed by each relevant Partner in accordance with Paragraph 14 of Schedule 7;
“Special Category Personal Data”	has the meaning set out in the Data Protection Legislation;
“Specialised Commissioning Budget”	means the budget identified by NHS England for the purpose of exercising the Joint Functions;
"Specialised Commissioning Functions"	means the statutory functions conferred on NHS England under Section 3B of the NHS Act 2006 and Regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);
“Specified Purpose”	means the purpose for which the Relevant Information is shared and processed to facilitate the exercise of the Joint Functions and Reserved Functions as specified in Schedule 7 *(Further Information Governance and Sharing Provisions)* to this Agreement;
“Specialised Services”	means the services commissioned in exercise of the Specialised Commissioning Functions;
“Specialised Services Contract”	a contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions;
“Specialised Services Provider”	a provider party to a Specialised Services Contract;
“Specialised Services Staff”	means the Staff carrying out the Joint Specialised Services Functions immediately prior to the date of this Agreement;
“Staff”	means the Partners’ employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of any Partner (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors’ and their sub-contractors’ personnel;
“System quality group”	means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice;
"Term"	the Initial Term, as may be varied by: (a) any extensions to this Agreement that are agreed under Clause 1.1 (Commencement and Duration); or

(b) the earlier termination of this Agreement in accordance with its terms;

"Terms of Reference"	means the Terms of Reference for the Joint Committee agreed between NHS England and the ICBs at the first meeting of the Joint Committee, a draft of which is included at Schedule 2 (Joint Committee – Terms of Reference);
"Triple Aim"	the duty on each of the Partners in making decisions about the exercise of their functions, to have regard to all likely effects of the decision in relation to: (a) the health and well-being of the people of England; (b) the quality of services provided to individuals by the NHS; (c) efficiency and sustainability in relation to the use of resources by the NHS;
"UK GDPR"	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
"Working Day"	any day other than Saturday, Sunday, a public or bank holiday in England.

2. References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.

3. The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses are Clauses in this Agreement.

4. References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.

5. References to a person or body shall not be restricted to natural persons and shall include a company, corporation or organisation.

6. Words importing the singular number only shall include the plural.

7. Use of the masculine includes the feminine and all other genders.

8. Where anything in this Agreement requires the mutual agreement of the Partners, then unless the context otherwise provides, such agreement must be in writing.

9. Any reference to the Partners shall include their respective statutory successors, employees and agents.

10. In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

11. Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

SCHEDULE 2: JOINT COMMITTEE – TERMS OF REFERENCE

[DN: the terms of reference should be agreed at the first meeting of the joint committee.]

[DN: the Partners should complete the terms of reference by making amendments where appropriate in accordance with the key to wording below.]

[DN: the completed terms of reference are not required to be included in the Agreement for signature].

Document name:		Draft Terms of Reference for the North West Specialised Services Committee (NWSSC)	
Senior Responsible Owner (SRO):		Andrew Bibby, Regional Director of Health & Justice and Specialised Commissioning (North West)	
Lead:		Insert Lead Name	
Version	1.0	**Date:**	[Publish Date]

Document management

Revision history

Version	Date	Summary of changes

Approved by

This document must be approved by:

To add

Related documents

Title	Owner	Location

Document control

The controlled copy of this document is maintained by NHS England. Any copies of this document held outside of that area, in whatever format (e.g. paper, e-mail attachment), are considered to have passed out of control and should be checked for currency and validity.

Introduction and purpose	From April 2023, Integrated Care Boards (ICBs) entering joint working agreements with NHS England will become jointly responsible, with NHS England, for commissioning the Joint Specialised Services set out in Schedule 3 of the Agreement, and for any associated Joint Functions set out in Schedule 4. NHS England and ICBs will form a statutory joint committee to collaboratively make decisions on the planning and delivery of the Joint Specialised Services, to improve health and care outcomes and reduce health inequalities. Joint Committees are intended as a transitional mechanism prior to ICB taking on full delegated commissioning responsibility. Subject to Clauses 7.1 and 7.2 of this Agreement (Further Collaborative Working), the Partners may, to such extent that they consider it desirable, table an item at the Joint Committee relating to any other of their functions that is not a Joint Specialised Service or a Joint Function to facilitate engagement, promote integration and collaborative working. The Partners may, from time to time, establish sub-groups or sub-committees of the Joint Committee, with such terms of reference as may be agreed between them. Any such sub-groups or sub-committees that are in place at the commencement of this Agreement may be documented in the Local Terms (Schedule 9).
The Terms of Reference	These Terms of Reference provide a template to support effective collaboration between NHS England and ICBs acting through Joint Committees in 2023/24. The Terms of Reference set out the role, responsibilities, membership, decision-making powers, and reporting arrangements of the Joint Committee in accordance with the Agreement between the ICB and NHS England. It is acknowledged that Joint Working Arrangements aim to give ICBs greater involvement in the commissioning of Specialised Services to better align and transform pathways of care around the needs of local populations. The Joint Committee will operate as the decision-making forum for exercising the agreed Joint Functions in accordance with the Agreement. By agreement, the Partners may use an alternative title for the Joint Committee that reflects local arrangements, for example, 'Commissioning Committee.' In the North West Region the Joint Committee will be known as the North West Specialised Services Committee (NWSSC)
Statutory Framework	The Partners have arranged to exercise the Functions jointly pursuant to section 65Z5 of the NHS Act 2006. The Joint Committee is established pursuant to section 65Z6 of the NHS Act 2006.

	Apart from as set out in the Agreement, the Joint Committee does not affect the statutory responsibilities and accountabilities of the Partners.
Role of the Joint Committee	The role of the Joint Committee is to provide strategic decision-making, leadership and oversight for the Joint Specialised Services and any associated activities. The Joint Committee will safely, effectively, efficiently and economically discharge the Joint Functions and deliver these Joint Specialised Services through the following key responsibilities: ▪ Determining the appropriate structure of the Joint Committee; ▪ Making joint decisions in relation to the planning and commissioning of the Joint Specialised Services, and any associated commissioning or statutory functions, for the population,for example, through undertaking population needs assessments; ▪ Making recommendations on the population-based Specialised Services financial allocation and financial plans; ▪ Oversight and assurance of the Joint Specialised Services in relation to quality, operational and financial performance, including co-ordinating risk and issue management and escalation, and developing the approach to intervention with Specialised Services Providers where there are quality or contractual issues; ▪ Identifying and setting strategic priorities and undertaking ongoing assessment and review of Joint Specialised Services within the remit of the Joint Committee, including tackling unequal outcomes and access; ▪ Supporting the development of partnership and integration arrangements with other health and care bodies that facilitate population health management and providing a forum that enables collaboration to integrate service pathways, improve population health and services and reduce health inequalities. This includes establishing links and working effectively with Provider Collaboratives and cancer alliances, and working closely with other ICBs, Joint Committees and NHS England where there are cross-border patient flows to providers; ▪ Ensuring the Joint Committee has effective engagement with stakeholders, including patients and the public, and involving them in decision-making; ▪ Ensuring the Joint Committee has appropriate clinical advice and leadership, including through Clinical Reference Groups and Relevant Clinical Networks; ▪ Commencing longer-term planning, particularly in view of the ICB(s) receiving full delegated commissioning responsibility in future; ▪ Discussing any matter which any member of the Joint Committee believes to be of such importance that it should be brought to the attention of the Joint Committee;

	▪ Where agreed by the Partners, overseeing the Collaborative Commissioning Agreements set out in the Joint Working Arrangement; ▪ Otherwise ensuring that the roles and responsibilities set out in the Agreement between the Partners are discharged. The Partners must implement such arrangements as are necessary to demonstrate good decision-making and compliance with all statutory duties, guidance and good practice, including ensuring that the Joint Committee has sufficient independent scrutiny of its decision-making and processes. Guidance: in the development of the Agreement a range of options have been considered for ensuring independent scrutiny and assurance of Joint Committee decision-making. In accordance with the preceding paragraph, whilst the Partners will need to determine appropriate local arrangements, it is recommended that they consider the adoption of a minimum of one independent member as part of the membership of the Joint Committee. This could be achieved by external recruitment to this specific role or by identifying a Non-Executive Director from a partner ICB. This role would carry no voting rights but provide additional accountability and assurance around decision-making in line with the Partners' statutory duties. PARTNERS SHOULD INSERT DETAIL ABOUT ARRANGEMENTS FOR INDEPENDENT SCRUTINY Further information on independent membership of the NWSSC is contained in the Membership Section. It is recommended that the Partners use the following section to detail any additional functions that will be in-scope of the Joint Committee. In particular, those ICB or NHS England functions that are identified for Further Collaborative Working at Clauses 7.1 and 7.2. PARTNERS TO INSERT ADDITIONAL ROLES AND RESPONSIBILITES The NWSSC will also be used as a forum for NHS England and ICBs to discuss the development of Retained Specialised Services. NHSE North West retains decision making responsibility for these services. The NWSSC will oversee and endorse the development plan for 2023/24 that will support the delivery of delegation of Specialised Services from 1 April 2024 The NWSSC will oversee and endorse a Target Operating Model (TOM) setting out how the functions and responsibilities will be discharged from April 2024. The Joint Committee must adhere to these Terms of Reference but may otherwise regulate its own procedure.
Accountability and reporting	The Joint Committee will be formally accountable to the Board of NHS England through the relevant NHS England regional governance structure for Specialised Services. In the North West the NWSSC will report to the NHS England Board via the North West Regional Management Team (RMT) and the North West Regional Commissioning Committee. Reporting will also be to the North

	West Regional Leadership Group (RLG), which includes ICB Chief Executives. In addition, the NWSSC will report separately to each of the three ICBs via the following Committees: NHS Lancashire and South Cumbria ICB – via Lancashire and South Cumbria Specialised Services System Board NHS Greater Manchester ICB – via Greater Manchester Specialised Services System Board NHS Cheshire and Mersey ICB – via Cheshire and Mersey ICB Board NHS ENGLAND MUST DESCRIBE THE RELEVANT REGIONAL GOVERNANCE STRUCTURE FOR SPECIALISED SERVICES HERE. The Joint Committee may report to the Delegated Commissioning Group (DCG) for Specialised Services on its proceedings and decisions. The Joint Committee's Chair(s) or, at the Chair's discretion, another member of the Joint Committee, may attend the DCG and report to the DCG on its proceedings. Where the DCG requests that the Joint Committee provides information or reports on its proceedings or decisions, the Partners must comply with that request within a reasonable timescale.
Membership	Core Membership Each of the Partners must nominate one Authorised Officer to be their representative at meetings of the Joint Committee. The Authorised Officers nominated by the Partners and present at a meeting of the Joint Committee comprise the voting membership of the Joint Committee. Each of the Partners may nominate a named substitute to attend meetings of the Joint Committee if its Authorised Officer is unavailable or unable to attend or because they are conflicted. Each of the Partners must ensure that its Authorised Officer (and any named substitute) is of a suitable level of seniority and duly authorised to act on its behalf and to agree to be bound by the final position or decision taken at any meeting of the Joint Committee. The Authorised Officers (or any substitute(s) appointed) form the Core Membership of the Joint Committee. Discretionary Membership Each of the Partners may be represented at meetings of the Joint Committee by representatives (who may be officers or, in the case of an ICB, non-executive members of the ICB) who may observe proceedings and contribute to the Joint Committee's deliberations as required, but these representatives will not have the right to vote. The Partners may identify individuals or representatives of other organisations that may be invited to observe proceedings and contribute to

	the Joint Committee's deliberations as required. These representatives will not have the right to vote. Independent Membership and Independent Scrutiny The Partners will appoint at least one Independent Member of the NWSSC The Independent Member will not have voting rights on the NWSSC The role of the Independent Member(s) is: • To provide constructive impartial challenge in the decision-making process; • To support the Partners to reach a consensus position wherever possible; • To support the NWSSC to exercise the Functions with reference to the statutory framework, good practice and the Triple Aim; and • To encourage the Partners to undertake effective stakeholder engagement and to have regard to the outcome of engagement exercises. • To role model and support a regional perspective in relation to Specialised Services Term of membership Each member of the Core Membership (and any substitute appointed) will hold their appointment until 31st March 2024 or until the NWSSC is superseded by governance arrangements in relation to the delegation of Specialised Services. ~~The term of appointment of each member expires on the first anniversary of the first Joint Committee meeting at which the member is in attendance.~~ Members will be eligible to be reappointed for further terms at the discretion of the Partners. Membership lists The Chair (or in the absence of a Chair, the Partners themselves) shall ensure that there is prepared (and updated from time to time) a list of the members and that this list is made available to the Partners.
Chair	At the first meeting of the Joint Committee in each financial year, the Core Membership shall select a Chair, or joint Chairs, from among the membership. The Chair(s) shall hold office until a replacement is appointed at the first meeting of the Joint Committee in that financial year and be eligible for re-appointment for 2 further terms. At the first scheduled Joint Committee meeting after the expiry of the Chair's term of office, the Core Membership will select a Chair, or joint Chairs, who will assume office at that meeting and for the ensuing term. If the Chair(s) is/are not in attendance at a meeting, the Core Membership will select one of the members to take the chair for that meeting.
Remuneration	The Partners shall prepare a scheme for the remuneration of any external members and for meeting the reasonable expenses incurred by other classes of membership of the Joint Committee. The scheme shall be reviewed on an annual basis.

Meetings	The Joint Committee shall meet quarterly, as a minimum. At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the Joint Committee shall prepare a schedule of meetings for the forthcoming year ("the Schedule"). Meetings of the Joint Committee can be conducted electronically where this is felt to be appropriate. The Chair(s) (or in the absence of a Chair, the Partners themselves) shall see that the Schedule is notified to the members. Either: ▪ NHS England, or ▪ The ICBs acting collectively, may call for a special meeting of the Joint Committee outside of the Schedule as they see fit, by giving notice of their request to the Chair. The Chair(s) may, following consultation with the Partners, confirm the date on which the special meeting is to be held and then issue a notice giving not less than 1 weeks' notice of the special meeting.
Quorum	A Joint Committee meeting is quorate if the following are in attendance: ▪ the Authorised Officer (or substitute) nominated by NHS England; ▪ each of the Authorised Officers (or substitutes) appointed by the ICBs.
Decisions and voting arrangements	The Joint Committee must seek to make decisions relating to the exercise of the Joint Functions and Joint Specialised Services on a consensus basis. The Partners must ensure that matters requiring a decision are anticipated and that sufficient time is allowed prior to Joint Committee meetings for discussions and negotiations between Partners to take place. In preparation for future delegation of Specialised Services and collaboration between them for this purpose, the ICBs should seek to adopt a common position on any matter to be decided. Decisions must be ratified by the Core Membership of the Joint Committee. Where it has not been possible, despite the best efforts of the Core Membership, to come to a consensus decision on any matter before the Joint Committee, the Chair(s) may require the decision to be put to a vote in accordance with the following provision. In developing these Terms of Reference, the Partners should discuss and agree to adopt one of the following options for decision-making in the event that consensus is not reach by the membership of the Joint Committee. *Option 1: ICB collective voting with an NHS England casting vote: the ICBs have a single collective vote and NHS England has a vote. Where there is deadlock, NHS England will have the casting vote at the meeting of the Joint Committee.*

	Option 2: Equal voting rights with NHS England casting vote: each ICB has a single vote and NHS England has a number of votes equal to the number of ICB votes. Where there is deadlock, NHS England has a casting vote at the meeting of the Joint Committee. *Option 3: Individual votes for each organisation coupled with an NHS England right to substitute an alternative decision: each organisation that is a Core Member of the Joint Committee has a single vote. However, NHS England can substitute an alternative decision if it considers it is in the best interests of the health service. The reasons for substituting a decision should be documented. Core Members also have a right to refer the decision to the regional director for review.* PARTNERS TO INSERT THE AGREED OPTION FROM THE LIST ABOVE. Option 2: Equal voting rights with NHS England casting vote: each ICB has a single vote and NHS England has a number of votes equal to the number of ICB votes. Where there is deadlock, NHS England has a casting vote at the meeting of the Joint Committee. In the event that the Regional Director of Specialised Commissioning uses their casting vote, this will be communicated to the NHSE Regional Director.
Conduct and conflicts of interest	Members of the Joint Committee will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and relevant organisational policies. The NHS Standards of Business Conduct policy is available from: https://www.england.nhs.uk/publication/standards-of-business-conduct-policy/ Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life). See: https://www.gov.uk/government/publications/the-7-principles-of-public-life. Members should refer to and act consistently with the NHS England guidance: *Managing Conflicts of Interest in the NHS: Guidance for staff and organisations*. See: https://www.england.nhs.uk/ourwork/coi/. Where any member of the Joint Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Joint Committee, that member must not participate in meetings (or parts of meetings) in which the relevant matter is discussed, either by participating in discussion or by voting. A Partner whose Authorised Officer is conflicted in this way may secure that their appointed substitute attend the meeting (or part of meeting) in the place of that member.
Confidentiality of proceedings	The Joint Committee is not subject to the Public Bodies (Admissions to Meetings) Act 1960. Admission to meetings of the Joint Committee is at the discretion of the Partners. All members in attendance at a Joint Committee are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the Partners.

Publication of notices, minutes and papers	The Partners shall provide sufficient resources, administration and secretarial support to ensure the proper organisation and functioning of the Joint Committee. The Chair(s) (or in the absence of a Chair, the Partners themselves) shall see that notices of meetings of the Joint Committee, together with an agenda listing the business to be conducted and supporting documentation, is issued to the Partners 1 week (or, in the case of a special meeting, 2 days) prior to the date of the meeting. The proceedings and decisions taken by the Joint Committee shall be recorded in minutes, and those minutes circulated in draft form within 2 weeks of the date of the meeting. The Joint Committee shall confirm those minutes at its next meeting.
Review of the Terms of Reference	These Terms of Reference will be reviewed annually.

SCHEDULE 3: JOINT SPECIALISED SERVICES

The following are the Specialised Services that NHS England has determined as being suitable and ready for greater ICB involvement:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease
		29S	Severe asthma
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Transcatheter Aortic Valve Replacement (TAVI)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08E	Neurosurgery - Low Volume Procedures (National)
		08F	Neurosurgery - Low Volume Procedures (Regional)
		08G	Neurosurgery - Low Volume Procedures (Neuroscience Centres)
		08O	Neurology
		08P	Neurophysiology
		08R	Neuroradiology
		08S	Neurosurgery
		08T	Mechanical Thrombectomy
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery
		34R	Orthopaedic revision
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
16	Adult specialist services for people living with HIV	14A	Adult Specialised Services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery
		29Z	Adult thoracic surgery services: outpatients
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection
72	Major trauma services (adults and children)	34T	Major trauma services
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer
		01K	Malignant mesothelioma
		01M	Head and neck cancer
		01N	Kidney, bladder and prostate cancer
		01Q	Rare brain and CNS cancer
		01U	Oesophageal and gastric cancer
		01V	Biliary tract cancer
		01W	Liver cancer
		01Y	Cancer Outpatients
		01Z	Testicular cancer
		04F	Gynaecological cancer
		19V	Pancreatic cancer
		24Y	Skin cancer
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence
		33B	Complex inflammatory bowel disease
		33C	Transanal endoscopic microsurgery
		33D	Distal sacrectomy for advanced and recurrent rectal cancer
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	23X(b)	Specialist paediatric surgery services - Gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05P	Prosthetics
135	Specialist paediatric surgery services	23X(a)	Specialist paediatric surgery services - General Surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Complex termination of pregnancy
ACC	Adult Critical Care	ACC	Adult critical care

SCHEDULE 4: JOINT FUNCTIONS

1. Introduction

1.1 This Schedule sets out in further detail the functions which are to be exercised jointly by the Partners, being, in summary:

1.1.1 decisions in relation to the commissioning and management of Joint Specialised Services;

1.1.2 planning Joint Specialised Services for the Population, including carrying out needs assessments;

1.1.3 undertaking reviews of Joint Specialised Services in respect of the Population;

1.1.4 supporting the management of the Specialised Commissioning Budget;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Joint Specialised Services with other health and social care bodies in respect of the Population where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Specialised Commissioning Functions.

2. General Obligations

2.1 The Partners are jointly responsible for planning the commissioning of the Joint Specialised Services in accordance with this Agreement, the Finance Guidance and the Mandated Guidance.

2.2 The role of the Joint Committee shall include:

2.2.1 planning the commissioning of the Joint Specialised Services;

2.2.2 assurance and oversight of the Joint Specialised Services, including compliance with the National Specifications and relevant Clinical Commissioning Policies;

2.2.3 identifying and setting strategic priorities for the Joint Specialised Services;

2.2.4 development of local commissioning expertise and advice structures.

2.3 The Joint Committee must comply with the National Specifications and relevant Clinical Commissioning Policies and ensure that all clinical Specialised Services Contracts accurately reflect Clinical Commissioning Policies and include the relevant National Specification where one exists in relation to the relevant Specialised Service.

Specific Obligations

3. Procurement and Contract Management

3.1 The Joint Committee will make procurement decisions and support NHS England to carry out any procurement processes in accordance with the Contracting Standard Operating Procedure.

3.2 In discharging these responsibilities, the Joint Committee must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance; any

applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services.

3.3 When the Joint Committee makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it is able to demonstrate compliance with requirements for the award of such Contracts, including that the decision was:

3.3.1 made in the best interest of patients, taxpayers and the population;

3.3.2 robust and defensible, with conflicts of interests appropriately managed;

3.3.3 made transparently; and

3.3.4 compliant with relevant Guidance and Legislation.

3.4 The Joint Committee shall be consulted on contracting decisions relevant to the exercise of the Joint Commissioning Functions and shall ensure the performance of the following general obligations:

3.4.1 oversee the management of the Specialised Services Contracts and, except in relation to payment, performance of the obligations of the commissioner in accordance with the relevant terms;

3.4.2 support the active management of the performance of the Specialised Services Providers in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services, including, as appropriate, by ensuring that timely action is taken to enforce contractual breaches, serve notices or work with Specialised Services Providers to address any issues;

3.4.3 review expenditure and collectively discuss how to obtain value for money in order to obtain value for money on behalf of NHS England;

3.4.4 where required, support NHS England to undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

3.4.5 collectively assess quality and outcomes including but not limited to clinical effectiveness, clinical governance, patient safety and the patient safety incident response framework, risk management, patient experience, and addressing health inequalities;

3.4.6 consider any necessary variations (to be managed by NHS England) to the relevant Specialised Services Contract or services in accordance with Clinical Commissioning Policies, National Specifications, service user needs and clinical developments, including, where necessary, developing and implementing a service development improvement plan with Specialised Service Providers where they are not in position to meet any new National Standard or amendment to a National Specification or Clinical Commissioning Policy that is published in the future;

3.4.7 agree information and reporting requirements to support NHS England to manage information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

3.4.8 conduct review meetings and support NHS England to undertake contract management, including the issuing of contract queries and agreeing any remedial action plan or related contract management processes.

3.5 Where NHS England considers that it is necessary for the effective commissioning of the Joint Specialised Services, it may take any such decision that it considers necessary and appropriate and shall report such decision to the next Joint Committee.

4. Finance

4.1 Without prejudice to Clause 8 (Finance) of this Agreement, the Joint Committee must support NHS England to manage each of the relevant Specialised Services Contracts, including by:

4.1.1 ensuring proper financial management and governance for Joint Specialised Services in accordance with the Finance Guidance;

4.1.2 supporting the move towards management of population-based budgets for Joint Specialised Services; and

4.1.3 considering and inputting into local price agreements, managing agreements or proposals for local variations and local modifications to be implemented by NHS England.

5. Service Planning and Strategic Priorities

5.1 The Joint Committee is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Joint Specialised Services.

5.2 In planning, commissioning and managing the Joint Specialised Services, the Partners must have processes in place to assess and monitor equitable patient access, in accordance with the access criteria set out in Clinical Commissioning Policies and National Specifications, taking action to address any apparent anomalies.

5.3 The Joint Committee must ensure that the Partners work with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Joint Specialised Services.

5.4 The Joint Committee shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Part A Retained Services should be delegated the Joint Committee or ICB.

6. Commissioning of High Cost Drugs

6.1 The Joint Committee must support the effective and efficient commissioning of High Cost Drugs for Joint Specialised Services.

6.2 The Joint Committee must develop and implement Shared Care Arrangements across the Area of the Joint Committee.

6.3 The Joint Committee must provide clinical and commissioning leadership in the commissioning and management of High Cost Drugs. This includes supporting the Specialised Service Provider pharmacy services and each Partner in the development access to medicine strategies, and minimising barriers that may exacerbate health inequalities.

6.4 The Joint Committee must ensure:

6.4.1 safe and effective use of High Cost Drugs in line with national Clinical Commissioning Policies;

6.4.2 effective introduction of new medicines;

6.4.3 appropriate use of Shared Care Arrangements, ensuring that they are safe and well monitored; and

6.4.4 consistency of prescribing and unwarranted prescribing variation are addressed.

6.5 The Joint Committee must have in place appropriate monitoring mechanisms, including prescribing analysis, to support the financial management of High Cost Drugs.

6.6 The Joint Committee must engage in the development, implementation and monitoring of initiatives that enable use of better value medicines. Such schemes include those at a local, regional or national level.

6.7 The Joint Committee must provide support to prescribing networks and forums, including but not limited to: immunoglobulin assessment panels, HIV prescribing networks and high cost drugs pharmacy networks.

7. Innovation and New Treatment

7.1 The Joint Committee shall support local implementation of innovative treatments for Joint Specialised Services.

8. Oversight and Assurance

8.1 The Joint Committee must at all times operate in accordance with:

8.1.1 the Oversight Framework published by NHS England;

8.1.2 any national oversight and assurance guidance in respect of Specialised Services and/or joint working arrangements; and

8.1.3 any other relevant NHS oversight and assurance guidance;

collectively known as the “Assurance Processes”.

8.2 The Joint Committee must develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes.

8.3 The Partners must provide any information and comply with specific actions in relation to the Joint Specialised Services, as required by NHS England, including metrics and detailed reporting in accordance with the Terms of Reference.

9. Mental Health, Learning Disabilities and Autism NHS-led Provider Collaboratives

9.1 The Joint Committee shall co-operate fully with NHS England in the development, management and operation of mental health, learning disability and autism NHS-led Provider Collaboratives including, where requested by NHS England, to consider the Provider Collaborative Arrangements where tabled by NHS England as an item for discussion under Clause 7.2.

10. Service Standards, National Specifications and Clinical Commissioning Policies

10.1 The Joint Committee shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.

10.2 The Joint Committee shall support local and national groups including Relevant Clinical Networks and Clinical Reference Groups that are involved in developing Clinical Commissioning Policies, National Specifications, National Standards and knowledge around Specialised Services.

10.3 The Joint Committee must comply with the National Specifications and relevant Clinical Commissioning Policies and ensure that all clinical Specialised Commissioning Contracts accurately reflect Clinical Commissioning Policies and include the relevant National Specification, where one exists in relation to the relevant Joint Specialised Service.

10.4 The Joint Committee must co-operate with any NHS England activities relating to the assessment of compliance against National Standards, including through the Assurance Processes.

10.5 The Joint Committee must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.

10.6 Where any Partner has identified that a Specialised Services Provider may not be complying with the National Standards set out in the relevant National Specification, the Joint Committee shall consider the action to take to address this in line with the Assurance Processes.

11. Networks

11.1 The Joint Committee shall participate in the planning, governance and oversight of the Relevant Clinical Networks, including involvement in agreeing the annual plan for each Relevant Clinical Network. The Partners shall seek to align the network priorities with system priorities and to ensure that the annual plan for the Relevant Clinical Network reflects local needs and priorities.

11.2 The Joint Committee shall actively support and participate in dialogue with Relevant Clinical Networks and shall ensure that there is a clear and effective mechanism in place for giving and receiving information with the Relevant Clinical Networks including network reports.

11.3 The Joint Committee shall support NHS England in the management of Relevant Clinical Networks.

11.4 The Partners shall actively engage and promote Specialised Service Provider engagement in appropriate Relevant Clinical Networks.

11.5 Where a Relevant Clinical Network identifies any concern, the Joint Committee shall seek to consider and review that concern as soon as is reasonably practicable and take such action, if any, as it deems appropriate.

11.6 The Joint Committee shall ensure that network reports are considered where relevant as part of exercising the Joint Functions.

12. Transformation

12.1 The Joint Committee must provide such support as may be requested by NHS England with transformational programmes which encompass the Joint Specialised Services.

12.2 The Joint Committee shall identify the pathways and services that are priorities for transformation according to the needs of their Population.

12.3 The Joint Committee shall oversee local implementation of transformation programmes in respect of the Joint Specialised Services for the Population.

13. Quality

13.1 The Joint Committee must ensure that appropriate arrangements for quality oversight are in place. This must include the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.

13.2 The Joint Committee must establish a plan to ensure that quality of the Specialised Services is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence.

13.3 The Joint Committee must ensure that the oversight of the quality of the Specialised Services is integrated with wider quality governance in the local system and aligns with NHS England quality escalation processes.

13.4 The Joint Committee must ensure that there is a System Quality Group to identify and manage concerns across the local system.

13.5 The Joint Committee must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.

13.6 The Joint Committee must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

14. Individual Funding Requests

14.1 The Partners shall provide any support required by NHS England in respect of determining an Individual Funding Request and implementing the decision of the Individual Funding Request panel.

15. Data Management and Analytics

15.1 The Joint Committee shall:

15.1.1 lead on standardised collection, processing, and sharing of data for Joint Specialised Services, in line with broader NHS England, Department of Health and Social Care and government data strategies;

15.1.2 lead on the provision of data and analytical service to support commissioning of Joint Specialised Services;

15.1.3 ensure collaborative working across the Partners on agreed programmes of work focusing on provision of pathway analytics.

15.2 The Partners shall:

15.2.1 share expertise, and, existing reporting tools, and shall ensure interpretation of data is made available to Joint Committees and other Partners to support the commissioning of the Joint Specialised Services;

15.2.2 work collaboratively with subject matter experts to ensure Partners are able to access data sources available to support the commissioning of the Joint Specialised Services.

15.3 The Joint Committee must ensure that the data reporting and analytical frameworks, as set out in Mandated Guidance or otherwise required by NHS England, are in place to support the commissioning of the Joint Specialised Services.

16. Incident Response

16.1 The Joint Committee shall:

16.1.1 support local incident management for Joint Specialised Services as appropriate to stated incident level; and

16.1.2 support national and regional incident management relating to Joint Specialised Services.

16.2 In the event that an incident is identified that has an impact on the Joint Specialised Services (such as potential failure of a Specialised Services Provider), the Joint Committee shall fully support the implementation of any requirements set by NHS England around the management of such incident and shall provide full co-operation to NHS England to enable a co-ordinated national approach to incident management. NHS England retains the right to take decisions at a national level where it determines this is necessary for the proper management and resolution of any such incident and the Joint Committee shall be bound by any such decision.

17. Freedom of Information and Parliamentary Correspondence

17.1 The Partners shall provide timely support in relation to the handling, management and response to all freedom of information and parliamentary correspondence relating to Joint Specialised Services.

SCHEDULE 5: RETAINED SERVICES

Part A Retained Services

The following are Retained Services that NHS England has determined are suitable but not yet ready for greater ICS leadership:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
4	Adult specialist respiratory services	29E	Management of central airway obstruction
		29V	Complex home ventilation
15	Adult specialist renal services	11T	Renal transplantation
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Blood and marrow transplantation services
		ECP	Extracorporeal photopheresis service
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services
55	Gender dysphoria services (children and adolescents)	22A	Gender identity development service for children and adolescents
56	Gender dysphoria services (adults)	22Z	Gender identity services
		42A	Gender dysphoria: genital surgery (trans feminine)
		42B	Gender dysphoria - genital surgery (trans masculine)
		42C	Gender dysphoria: chest surgery (trans masculine)
		42D	Gender dysphoria - non-surgical services
		42E	Gender dysphoria: other surgical services
58	Specialist adult gynaecological surgery and urinary surgery services for females	04K	Specialised Services for women with complications of mesh inserted for urinary incontinence and vaginal prolapse (16 years and above)
		04L	Reconstructive surgery and congenital anomalies of the female genital tract
65	Specialist services for adults with infectious diseases	18T	Tropical Disease
82	Paediatric and perinatal post mortem services	F23	Paediatric and perinatal post mortem services
87	Positron emission tomography-computed tomography services (adults and children)	01P	Positron emission tomography-computed tomography services (PETCT)
89	Primary malignant bone tumours service (adults and adolescents)	01O	Primary malignant bone tumours service (adults and adolescents)
101	Severe intestinal failure service (adults)	12Z	Severe intestinal failure service
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01L	Soft tissue sarcoma
		01X	Penile cancer
111	Clinical genomic services (adults and children)	20G	Genomic laboratory testing services
		20H	Pre-Implantation genetic diagnosis and associated in-vitro fertilisation services
		20Z	Specialist clinical genomics services
		MOL	Molecular diagnostic service
114	Specialist haemoglobinopathy services (adults and children)	38S (DPC)	Sickle cell anaemia -direct patient care
		38T (DPC)	Thalassemia - direct patient care
		38X (HCC)	Haemoglobinopathies coordinating centres (HCCs)
		38X (SHT)	Specialist Haemoglobinopathies Teams (SHTs)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05C	Specialist augmentative and alternative communication aids
		05E	Specialist environmental controls
137	Spinal cord injury services (adults and children)	06A	Spinal cord injury services (adults and children)
6	Adult secure mental health services	22S(a)	Secure and specialised mental health services (adult) (Medium and low) -including LD / ASD / WEMS / ABI / DEAF
		22S(b)	Secure and specialised mental health services (adult) (Medium and low) - Excluding LD / ASD / WEMS / ABI / DEAF
		22S(c)	Secure and specialised mental health services (adult) (Medium and low) - ASD
		22S(d)	Secure and specialised mental health services (adult) (Medium and low) - LD
		22S(e)	Secure and specialised mental health services (adult) Medium Secure Female WEMS
		22S(f)	Secure and specialised mental health services (adult) (Medium and low) - ABI
		22S(g)	Secure and specialised mental health services (adult) (Medium and low) - DEAF
		YYY	Specialised mental health services exceptional packages of care
8	Adult specialist eating disorder services	22E	Adult specialist eating disorder services
32	Children and young people's inpatient mental health service	22C	Tier 4 CAMHS (MSU)
		24E	Tier 4 CAMHS (children's service)
		23K	Tier 4 CAMHS (general adolescent inc eating disorders)
		23L	Tier 4 CAMHS (low secure)
		23O	Tier 4 CAMHS (PICU)
		23U	Tier 4 CAMHS (LD)
		23V	Tier 4 CAMHS (ASD)
98	Specialist secure forensic mental health services for young people	24C	FCAMHS
102	Severe obsessive compulsive disorder and body dysmorphic disorder service (adults and adolescents)	22F	Severe obsessive compulsive disorder and body dysmorphic disorder service
116	Specialist mental health services for Deaf adults	22D	Specialist mental health services for Deaf adults
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services
133	Specialist services for severe personality disorder in adults	22T	Specialist services for severe personality disorder in adults

Part B Retained Services

The following are Retained Services that NHS England has determined will remain nationally commissioned:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
1	Adult ataxia telangiectasia services	23G	Adult ataxia telangiectasia services
2A	Adult oesophageal gastric services in the form of gastro-electrical stimulation for patients with intractable gastroparesis	39A	Gastro-electrical stimulation for patients with intractable gastroparesis
4	Adult specialist respiratory services	29G	Primary ciliary dyskinesia management (adult)
11	Adult specialist neurosciences services	08U	Transcranial magnetic resonance guided focused ultrasound (TcMRgFUS)
		43A	Inherited white matter disorders diagnostic and management service for adults
12	Adult specialist ophthalmology services	37D	Retinal Gene Therapy
		37E	Limbal Cell Treatment (Holoclar)
14	Adult specialist pulmonary hypertension services	13G	Adult specialist pulmonary hypertension services
15	Adult specialist renal services	36E	Cystinosis
19	Alkaptonuria service (adults)	20A	Alkaptonuria service (adults)
19A	Alpha 1 antitrypsin services (adults)	29H	Alpha 1 antitrypsin services
20	Alström syndrome service (adults and children)	H23	Alström syndrome service (adults and children)
21	Ataxia telangiectasia service for children	23J	Ataxia telangiectasia service for children
21A	Atypical haemolytic uraemic syndrome services (adults and children)	11A	Atypical haemolytic uraemic syndrome services (adults and children)
22	Autoimmune paediatric gut syndromes service	16A	Autoimmune paediatric gut syndromes service
23	Autologous intestinal reconstruction service for adults	12A	Autologous intestinal reconstruction service for adults
24	Bardet-Biedl syndrome service (adults and children)	20B	Bardet-Biedl syndrome service (adults and children)
25	Barth syndrome service (adults and children)	36A	Barth syndrome service (male adults and children)
26	Beckwith-Wiedemann syndrome with macroglossia service (children)	36B	Beckwith-Wiedemann syndrome with macroglossia service (children)
27	Behçet's syndrome service (adults and adolescents)	16B	Behçet's syndrome service (adults and adolescents)
28	Bladder exstrophy service (children)	D23	Bladder exstrophy service (children)
31	Pain-related complex cancer late effects rehabilitation service (adults)	01A	Breast radiotherapy injury rehabilitation service
33	Choriocarcinoma service (adults and adolescents)	01I	Choriocarcinoma service (adults and adolescents)
34	Chronic pulmonary aspergillosis service (adults)	29Q	Chronic pulmonary aspergillosis service (adults)
37	Complex childhood osteogenesis imperfecta service	K23	Complex childhood osteogenesis imperfecta service
38	Complex Ehlers Danlos syndrome service (adults and children)	M23	Complex Ehlers Danlos syndrome service (adults and children)
39	Complex neurofibromatosis type 1 service (adults and children)	08A	Complex neurofibromatosis type 1 service (adults and children)
41	Complex tracheal disease service (children)	B23	Complex tracheal disease service (children)
42	Congenital hyperinsulinism service (children)	N23	Congenital hyperinsulinism service (children)
43	Craniofacial service (adults and children)	15A	Craniofacial service (adults and children)
44	Cryopyrin associated periodic syndrome service (adults and children)	02A	Cryopyrin associated periodic syndrome service (adults and children)
46	Diagnostic service for amyloidosis (adults and children)	02B	Diagnostic service for amyloidosis (adults and children)
47	Diagnostic service for primary ciliary dyskinesia (adults and children)	29D	Diagnostic service for primary ciliary dyskinesia (adults and children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
48	Diagnostic service for rare neuromuscular disorders (adults and children)	08B	Diagnostic service for rare neuromuscular disorders (adults and children)
49	Encapsulating peritoneal sclerosis treatment service (adults)	11D	Encapsulating peritoneal sclerosis treatment service (adults)
50	Epidermolysis bullosa service (adults and children)	24A	Epidermolysis bullosa service (adults and children)
51	Extra corporeal membrane oxygenation service for adults with respiratory failure	29F	Extra corporeal membrane oxygenation service for adults with respiratory failure
52	Extra corporeal membrane oxygenation service for neonates, infants and children with respiratory failure	R23	Extra corporeal membrane oxygenation service for neonates, infants and children with respiratory failure
53	Ex-vivo partial nephrectomy service (adults)	01D	Ex-vivo partial nephrectomy service (adults)
56A	Hand and upper limb transplantation service (adults)	40A	Hand and upper limb transplantation service (adults)
56ZA	Ovarian and testicular tissue cryopreservation for patients receiving gonadotoxic treatment who are at high risk of infertility and cannot store mature eggs or sperm	44A	Gonadal tissue cryopreservation services for children and young people at high risk of gonadal failure due to treatment or disease
57	Heart and lung transplantation service (including mechanical circulatory support) (adults and children)	13N	Heart and lung transplantation
		13V	Ventricular Assist Devices
58	Specialist adult gynaecological surgery and urinary surgery services for females	04J	Urinary Fistula
61	Specialist dermatology services (adults and children)	43S	Stevens-Johnson syndrome and toxic epidermal necrolysis (SJS-TEN)
62	Specialist metabolic disorder services (adults and children)	36F	CLN2 Disease
65	Specialist services for adults with infectious diseases	18D	Human T- Cell Lymphotropic Virus Type 1 and 2
		18J	Adult high consequence infectious airborne disease service
		18L	Adult high consequence infectious contact disease service
		18U	Infectious disease isolation units
66	Hyperbaric oxygen treatment services (adults and children)	28Z	Hyperbaric oxygen treatment services (adults and children)
67	Insulin-resistant diabetes service (adults and children)	27A	Insulin-resistant diabetes service (adults and children)
68	Islet transplantation service (adults)	27B	Islet transplantation service (adults)
69	Liver transplantation service (adults and children)	19T	Liver transplantation service (adults and children)
70	Lymphangioleiomyomatosis service (adults)	29C	Lymphangioleiomyomatosis service (adults)
71	Lysosomal storage disorder service (adults and children)	36C	Lysosomal storage disorder service (adults and children)
73	McArdle's disease service (adults)	26A	McArdle's disease service (adults)
75	Mitochondrial donation service	20D	Mitochondrial donation service
76	NF2-schwannomatosis service (adults and children)	08C	Neurofibromatosis type 2 service (adults and children)
77	Neuromyelitis optica service (adults and adolescents)	08D	Neuromyelitis optica service (adults and adolescents)
79	Ocular oncology service (adults)	01H	Ocular oncology service (adults)
80	Ophthalmic pathology service (adults and children)	37A	Ophthalmic pathology service (adults and children)
81	Osteo-odonto-keratoprosthesis service for corneal blindness (adults)	37B	Osteo-odonto-keratoprosthesis service for corneal blindness (adults)
84	Paediatric intestinal pseudo-obstructive disorders service	12B	Paediatric intestinal pseudo-obstructive disorders service
85	Pancreas transplantation service (adults)	27C	Pancreas transplantation service (adults)
86	Paroxysmal nocturnal haemoglobinuria service (adults and adolescents)	03A	Paroxysmal nocturnal haemoglobinuria service (adults and adolescents)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
88	Primary ciliary dyskinesia management service (adults and children)	29P	Primary ciliary dyskinesia management service (adults and children)
90	Proton beam therapy service (adults and children)	01B	Proton beam therapy service (adults and children)
91	Pseudomyxoma peritonei service (adults)	01F	Pseudomyxoma peritonei service (adults)
92	Pulmonary hypertension service for children	13J	Pulmonary hypertension service for children
93	Pulmonary thromboendarterectomy service (adults and adolescents)	13M	Pulmonary thromboendarterectomy service (adults and adolescents)
95	Rare mitochondrial disorders service (adults and children)	36D	Rare mitochondrial disorders service (adults and children)
97	Retinoblastoma service (children)	01G	Retinoblastoma service (children)
99	Severe acute porphyria service (adults and children)	27D	Severe acute porphyria service (adults and children)
100	Severe combined immunodeficiency and related disorders service (children)	16C	Severe combined immunodeficiency and related disorders service (children)
103	Small bowel transplantation service (adults and children)	12D	Small bowel transplantation service (adults and children)
103A	Specialist adult haematology services	03T	Thrombotic thrombocytopenic purpura (TTP)
104	Specialist burn care services (adults and children)	09A	Specialist burn care services (adults)
		09C	Specialist burn care services (children)
106A	Specialist colorectal surgery services (adults)	33E	Cytoreductive surgery and hyperthermic intraperitoneal chemotherapy for colorectal cancer
108	Specialist ear, nose and throat services for children	32E	Auditory brainstem implants for children
114	Specialist haemoglobinopathy services (adults and children)	38S (NHP)	National haemoglobinopathy panel (NHP)
119	Specialist neuroscience services for children	08M	Spinal muscular atrophy: gene therapy
		43C	Inherited white matter disorders diagnostic and management service for children
		73M	Children's Epilepsy Surgery Service
		T23	Multiple Sclerosis Management service for children
		U23	Open Fetal surgery to treat fetuses with open spina bifida
123	Specialist paediatric liver disease service	C23	Specialist paediatric liver disease service
130	Specialist services for children with infectious diseases	14C	Specialist services for children with infectious diseases: HIV
		18K	High consequence infectious airborne disease services for children
		18M	High consequence infectious contact disease services for children
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19A	Total pancreatectomy with islet auto transplant
138	Stem cell transplantation service for juvenile idiopathic arthritis and related connective tissue disorders (children)	P23	Stem cell transplantation service for juvenile idiopathic arthritis and related connective tissue disorders (children)
139	Stickler syndrome service (adults and children)	20C	Stickler syndrome diagnostic service (adults and children)
139B	Uterine transplantation services (adults)	04U	Uterine transplantation services
140	Vein of Galen malformation service (adults and children)	A23	Vein of Galen malformation service (adults and children)
142	Wolfram syndrome service (adults and children)	Q23	Wolfram syndrome service (adults and children)
143	DNA Nucleotide Excision Repair Disorders Service (adults and children)	24D	DNA Nucleotide Excision Repair Disorders Service
6	Adult secure mental health services	22O	Offender personality disorder
		22U(a)	Secure and specialised mental health service (adult) (High) - Excluding LD
		22U(b)	Secure and specialised mental health service (adult) (High) - LD
74	Mental health service for deaf children & adolescents	22B	Mental health service for deaf children & adolescents

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
91A	Psychological medicine inpatient services for severe and complex presentations of medically unexplained physical symptoms (adults)	22V	Psychological medicine inpatient services for severe and complex presentations of medically unexplained physical symptoms
141	Integrated veterans' mental health and wellbeing service	22G	Veterans' mental health complex treatment service
		05V	Veterans' prosthetic service

SCHEDULE 6: RESERVED FUNCTIONS

1. Introduction

1.1 In accordance with Clause 6.2 of this Agreement, all functions of NHS England other than those defined as Joint Functions, are Reserved Functions.

1.2 This Schedule sets out further provision regarding the carrying out of the Reserved Functions as they relate to the Joint Functions.

1.3 The ICB Partners will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

1.4 The following functions and related activities shall continue to be exercised by NHS England.

2. Retained Services

2.1 NHS England shall commission the Retained Services set out in Schedule 5.

3. Reserved Specialised Service Functions

3.1 In addition to the commissioning of Retained Services set out in Schedule 5, NHS England shall also carry out the functions set out in this Schedule 6 in respect of the Joint Specialised Services.

4. Oversight and Assurance

4.1 NHS England shall be responsible for developing national oversight and assurance guidance on joint working arrangements for Specialised Services.

4.2 NHS England shall be responsible for assuring the Joint Working Arrangements. Such assurance shall be undertaken in accordance with the Assurance Processes.

4.3 NHS England shall host a Delegated Commissioning Group that will undertake an assurance role in compliance with the Assurance Processes. This assurance role shall include monitoring and suggesting solutions to mitigate systemic risk to Joint Specialised Service provision.

5. Clinical Leadership and Clinical Reference Groups

5.1 NHS England shall be responsible for the following:

5.1.1 providing clinical leadership, advice and guidance to the Joint Committee in relation to the Joint Specialised Services;

5.1.2 supporting ICB Partners to develop clinical leadership for Joint Specialised Services; and

5.1.3 providing clinical and public health leadership for Specialised Services.

5.2 NHS England will host Clinical Reference Groups, which will lead on the development and publication of the following for Specialised Services:

5.2.1 Clinical Commissioning Policies;

5.2.2 National Specifications, including National Standards for each of the Specialised Services.

6. Clinical Networks

6.1 Unless otherwise agreed between the Partners, NHS England shall put in place contractual arrangements and funding mechanisms for the commissioning of the Relevant Clinical Networks.

6.2 NHS England shall be responsible for the following in respect of the Relevant Clinical Networks:

6.2.1 developing national policy for the Relevant Clinical Networks;

6.2.2 developing and approving the national specifications for the Relevant Clinical Networks;

6.2.3 maintaining links with other NHS England national leads for clinical networks not focused on Specialised Services;

6.2.4 convening or supporting national networks of the Relevant Clinical Networks;

6.2.5 agreeing the annual plan for each Relevant Clinical Network with the involvement of the Joint Committee and Relevant Clinical Network, ensuring these reflect national and regional priorities;

6.2.6 managing Relevant Clinical Networks jointly with the Joint Committee; and

6.2.7 agreeing and commissioning the hosting arrangements of the Relevant Clinical Networks.

7. Complaints

7.1 NHS England shall manage all complaints in respect of the Joint Specialised Services and Reserved Services.

8. Procurement

8.1 In relation to procurement, NHS England shall be responsible for:

8.1.1 setting standards and agreeing frameworks and processes for provider selections and procurements for Specialised Services;

8.1.2 monitoring and providing advice, guidance and expertise on the overall provider market in relation to Specialised Services;

8.1.3 running provider selection and procurement processes for Specialised Services.

9. Contracting

9.1 NHS England shall retain the following obligations in relation to contracting:

9.1.1 except where 9.1.2 applies, entering into Specialised Commissioning Contracts with Specialised Service Providers as Co-ordinating Commissioner including negotiation of the Specialised Services Contracts and creating all contract documents (including indicative activity plans) and

schedules for inclusion in the Specialised Services Contracts, including the process of negotiation;

9.1.2 where NHS England in its absolute discretion agrees to enter into Specialised Commissioning Contracts with Specialised Service Providers as Associate Commissioner and perform all contracting duties required of an associate as well as ensure oversight of the relevant Specialised Commissioning Contracts through the Joint Committee;

9.1.3 setting, publishing or making otherwise available the Contracting Standard Operating Procedure and other Mandated Guidance detailing contracting strategy and policy for Specialised Services; and

9.1.4 providing and distributing contracting support tools and templates to the Partners.

9.2 NHS England shall keep a record of all of the Specialised Services Contracts setting out the following details in relation to each Specialised Services Contract

9.2.1 name of the Specialised Services Provider;

9.2.2 the name by which the Specialised Services Provider is known;

9.2.3 commissioner name;

9.2.4 Specialised Services Contract start date and end date;

9.2.5 description of Specialised Services;

9.2.6 location of provision of services; and

9.2.7 amounts payable under the Specialised Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

10. Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

10.1 NHS England shall commission and design Provider Collaborative Arrangements for mental health, learning disabilities and autism services. Where it considers appropriate, NHS England shall seek the input of the Joint Committee in relation to relevant Provider Collaborative Arrangements.

11. Finance

11.1 NHS England shall be responsible for:

11.1.1 Performing all necessary financial transactions associated with Specialised Services unless expressly agreed and set out in Local Terms;

11.1.2 Setting financial policy and frameworks and developing the support tools necessary to enable commissioners to plan and deliver against a population-based allocation;

11.1.3 Setting financial allocations for Specialised Services, including the move from historic actual to population-based allocations and including growth, inflation and efficiency targets;

11.1.4 Consolidating and reporting plans and in-year financial delivery against the Specialised Services Budget;

11.1.5 Developing financial impact assessments for National Specifications;

11.1.6 Overseeing dispute escalation and resolution where there are material changes to out-of-area cross-border flows;

11.1.7 Supporting the Joint Committee to ensure the financial delivery of the Joint Specialised Services according to financial business rules and financial frameworks including but not limited to:

11.1.7.1 financial planning;

11.1.7.2 investment and commissioning decision-making;

11.1.7.3 budgetary control and delivery of efficiency targets;

11.1.7.4 financial reporting and accounting;

11.1.7.5 system financial oversight.

12. Individual Funding Requests (IFRs)

12.1 NHS England shall be responsible for the following:

12.1.1 Leading on IFR policy, supporting IFR governance and managing the IFR process; and

12.1.2 Providing pharmacy activity input and public health medicines expertise into IFR decisions.

13. Data Management and Analytics

13.1 NHS England shall:

13.1.1 Lead on data collection, data acquisition and reporting;

13.1.2 Provide leadership of data management and analytics to support the Partners, including professional network development, workforce development and information dissemination;

13.1.3 Set Specialised Services data strategy and ensure alignment with broader NHS England, Department of Health and Social Care and government data strategies;

13.1.4 Secure appropriate resource to support a national service for data processing and analytics for Specialised Services;

13.1.5 Oversee standardised collection, processing and sharing of data used to support Specialised Services commissioning across the Partners, in line with national data strategy;

13.1.6 Work collaboratively with all Partners to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services; and

13.1.7 Support ICB data and analytic functions and wider data and analytic networks to develop, deploy locally and utilise business intelligence tools.

14. Pharmacy and Optimisation of High Cost Drugs

14.1 In respect of pharmacy and optimisation of High Cost Drugs, NHS England shall:

14.1.1 support the Joint Committee on strategy for access to medicines, minimising barriers to health inequalities;

14.1.2 provide financial management of High Cost Drugs spend, including prescribing analysis, to identify, scope, engage, deliver and record better value medicines strategy and initiatives;

14.1.3 commission High Cost Drugs for Retained Services and of High Cost Drugs for Joint Specialised Services working jointly with Joint Committee;

14.1.4 ensure consistency of prescribing in line with Clinical Commissioning Policies, introduction of new medicines, and addressing unwarranted prescribing variation;

14.1.5 set medicines commissioning policy and criteria for access to certain medicines commissioned by Specialised Services including developing any necessary support tools;

14.1.6 provide expert medicines advice and input into all Specialised Services activities; and

14.1.7 provide direction and support to medicines leads at ICB level to support discharge of duties and delivery of strategic objectives and National Standards.

15. Quality

15.1 In respect of quality, NHS England shall:

15.1.1 work with the Joint Committee to ensure oversight of Specialised Services through quality oversight and risk management;

15.1.2 ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group, or other appropriate forums, as necessary;

15.1.3 ensure that the Joint Specialised Services are aligned and integrated with broader clinical quality governance and processes;

15.1.4 when quality issues relating to Specialised Services are identified, facilitate improvement through programme support, and mobilise intensive support when required on specific quality issues;

15.1.5 facilitate review of Specialised Services where concerns arise, utilising peer reviews or clinical assessment, as appropriate;

15.1.6 ensure all relevant intelligence is shared appropriately for quality and safety monitoring, including between organisations and at system quality groups or appropriate alternative forums;

15.1.7 identify and act upon issues and concerns that cross multiple ICBs, coordinating response and management as necessary;

15.1.8 provide guidance on quality and clinical governance matters and benchmark available data;

15.1.9 support Joint Committees to identify key themes and trends across their Area and utilise data and intelligence to respond and monitor as necessary; and

15.1.10 facilitate and support the national quality governance infrastructure (Specialised Commissioning Quality and Governance Group).

16. Service standards

16.1 NHS England shall carry out the following:

16.1.1 development, engagement and approval of National Standards for Specialised Services (including National Specifications, Clinical Commissioning Policies, quality and data standards);

16.1.2 production of national commissioning products and tools to support commissioning of Specialised Services; and

16.1.3 maintenance and publication of the 'Manual' of prescribed Specialised Services and engagement with the Department of Health and Social Care on policy matters.

17. Transformation

17.1 NHS England shall be responsible for:

17.1.1 providing leadership for transformation programmes and projects that have been identified as priorities for national coordination and support, and / or are national priorities for the NHS, including supporting delivery of commitments in the NHS Long Term Plan;

17.1.2 co-production and co-design of transformation programmes with the Joint Committee and wider stakeholders; and

17.1.3 supporting Joint Committees in co-ordinating and enabling Specialised Services transformation programmes for Joint Specialised Services where necessary.

18. Incident Response

18.1 NHS England shall, lead on incident management for Specialised Services.

18.2 NHS England shall lead on monitoring, planning and support for service and operational resilience and provide support to the Joint Committee to develop its oversight of these arrangements.

18.3 NHS England shall respond to specific service interruptions; for example. supplier, workforce challenges and provide support to the Joint Committee in any response to interruptions.

19. Innovation and New Treatment

19.1 NHS England shall ensure the implementation of innovative treatments for Joint Specialised Services and Retained Services such as Advanced Medicinal Therapy Products (ATMPs), recommended by NICE technology appraisals within statutory requirements.

19.2 NHS England shall provide national leadership for innovative treatments with significant service impacts including liaison with NICE.

SCHEDULE 7: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

1. Introduction

1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the Partners on a Need To Know basis, in order to enable the Partners to exercise their functions in pursuance of this Agreement.

1.2. References in this Schedule *(Further Information Governance and Sharing Provisions)* to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3. This Schedule and the Data Sharing Agreements entered into under this Schedule are designed to:

1.3.1. provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Partners;

1.3.2. describe the purposes for which the Partners have agreed to share Relevant Information;

1.3.3. set out the lawful basis for the sharing of information between the Partners, and the principles that underpin the exchange of Relevant Information;

1.3.4. describe roles and structures to support the exchange of Relevant Information between the Partners;

1.3.5. apply to the sharing of Relevant Information relating to Specialised Services Providers and their Staff;

1.3.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;

1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;

1.3.8. apply to the activities of the Partners' Staff; and

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

2. Purpose

2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Joint Functions and NHS England's Reserved Functions.

2.2. Each Partner must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Partners must obtain data in order to achieve the Specified Purpose. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant Legislation and Guidance.

3. Benefits of information sharing

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

4. Lawful basis for sharing

4.1. The Partners shall comply with all relevant Data Protection Legislation requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2. The Partners shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.

4.3. Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

5. Restrictions on use of the Shared Information

5.1. Each Partner shall only process the Relevant Information as is necessary to achieve the Specified Purpose and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

5.2. Access to, and processing of, the Relevant Information provided by a Partner must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Data Protection Legislation requirements, and the Partners' Staff should only have access to Personal Data on a justifiable Need to Know basis.

5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the Partners.

5.4. Neither Partner shall subcontract any processing of the Relevant Information without the prior consent of the other Partner. Where a Partner subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

5.5. The Partners shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

5.6. Any particular restrictions on use of certain Relevant Information should be included in a Personal Data Agreement.

6. Ensuring fairness to the Data Subject

6.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the Partners will take the following measures as reasonably required:

6.1.1. amendment of internal guidance to improve awareness and understanding among Staff;

6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering

the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

6.1.3. ensuring that information and communications relating to the processing of data is clear and easily accessible; and

6.1.4. giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.

6.2. Each Partner shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.

6.3. The Partners shall reasonably cooperate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

6.4. Further provision in relation to specific data flows may be included in a Personal Data Agreement between the Partners.

7. Governance: Staff

7.1. The Partners must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.

7.2. The Partners agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Partners' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018) the employing Partners must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

7.3. The Partners shall ensure that all Staff required to access Personal Data (including Special Category Personal Data are informed of the confidential nature of the Personal Data. The Partners shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

Each Party shall provide evidence (further to any reasonable request) that all personnel that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.

7.4. The Partners shall ensure that:

7.4.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information; and

7.4.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and

7.4.3. specific limitations on the Staff who may have access to the Information are set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8. Governance: Protection of Personal Data

8.1. At all times, the Partners shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.

8.2. Wherever possible (in descending order of preference), only anonymised information, or, strongly or weakly pseudonymised information will be shared and processed by the Partners. The Partners shall cooperate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.

8.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis.

8.4. If any Partner

8.4.1. becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

8.4.2. becomes aware of any security vulnerability or breach in respect of the Relevant Information,

it shall promptly, within 48 hours, notify the other Partners. The Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.

8.5. In processing any Relevant Information further to this Agreement, the Partners shall process the Personal Data and Special Category Personal Data only:

8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

8.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body;

8.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.

8.6. The Partners shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protected the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

8.6.1. take account of the nature, scope, context and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and

8.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data, and having the nature of the Personal Data (and Special Category Personal Data) which is to be protected.

8.7. In particular, teach Partner shall:

8.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;

8.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

8.7.3. obtain prior written consent from the originating Partner in order to transfer the Relevant Information to any third party;

8.7.4. permit any other Partner or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Partner to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

8.7.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

The Partners shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8.8. The Partners shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.9. The Partners' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third party security measures.

9. Governance: Transmission of Information between the Partners

9.1. This paragraph supplements paragraph 8 of this Schedule.

9.2. Transfer of Personal Data between the Partners shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record / data is identified.

9.4. Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement entered into in accordance with this Schedule.

9.5. Each Partner shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

9.6. The Partners' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Partners.

10. Governance: Quality of Information

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

11. Governance: Retention and Disposal of Shared Information

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

11.2. Each Partner shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

11.3. If a Partner is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in accordance with this Schedule, it shall notify the other Partners in writing of that retention, giving details of the documents or materials that it must retain.

11.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all good practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

11.5. The Partners shall set out any special retention periods in a Data Sharing Agreement where appropriate.

11.6. The Partners shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

11.7. Each Partner shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

11.8. Electronic records will be considered for deletion once the relevant retention period has ended.

11.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Partner shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12. Governance: Complaints and Access to Personal Data

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

12.2. Complaints about information sharing shall be reported to the Single Points of Contact and the Joint Committee. Complaints about information sharing shall be routed through each Partners' own complaints procedure unless otherwise provided for in the Joint Working Arrangements or determined by the Joint Committee.

12.3. The Partners shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.

12.4. Basic details of the Agreement shall be included in the appropriate log under each Partner's Publication Scheme.

13. Governance: Single Points of Contact

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

14. Monitoring and review

14.1. The Partners shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 8: MANDATED GUIDANCE

Generally applicable Mandated Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- IG Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable guidance relating to the use of data and data sets for reporting.

Workforce

- Guidance on the Employment Commitment.

Finance

- Guidance on NHS System Capital Envelopes.
- Managing Public Money (HM Treasury).

Specialised Services Mandated Guidance

- Commissioning Change Management Business Rules.
- Cashflow Standard Operating Procedure.
- Finance and Accounting Standard Operating Procedure.
- Provider Collaborative Guidance.
- Clinical Commissioning Policies.
- National Specifications.
- National Standards.
- The ‘Manual’ for Specialised Commissioning.

SCHEDULE 9: LOCAL TERMS

Guidance notes are provided in red text and can be deleted prior to completing the agreement.

This Schedule should be used by the Partners to agree local terms to the Agreement. Headings and guidance have been provided for areas that may need local agreement. Additional headings can be added as required to support local arrangements.

Sufficient detail should be provided to describe what both the ICBs and NHS England have agreed to do, including any role of the relevant Joint Committee, where required.

General

Where there is a dispute as to the content of this Schedule, the Partners should follow the Disputes Resolution procedure set out at Clause 18.

Following signature of the Agreement, this Schedule can be amended by the Partners using the Variations procedure at Clause 10.

Part 1 – Further Governance Arrangements

The Partners can use this Part for any governance arrangements not covered by the main agreement or the existing Schedules.

It is advised that sub-committees (those forums with decision-making power) and sub-groups (those forums without decision-making power, but are advisory in nature) are set out in this part. It is advised that the role, purpose and membership of the sub-committees or sub-groups are set out in this part.

All local arrangements will be included in the Target Operating Model which will be approved by the NWSSC.

Part 2 – Workforce Arrangements

It is recognised that, in 2023/24, NHS England will retain the relevant specialised commissioning workforce which will support the arrangements described in this Agreement. The Partners can use this Part to detail any arrangements relating to the supporting workforce for the Joint Functions. As examples, this may include setting out the list of activities that NHS England teams will carry out, the support that will be provided to ICBs and any other relevant arrangements. The Partners may also wish to detail how any additional requests will be managed and agreed to, including any role of the Joint Committee.

All local arrangements will be included in the Target Operating Model which will be approved by the NWSSC

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Appendix Three: Frequently Asked Questions

FAQs

Note: these FAQs were reviewed and reissued on 21 February 2023. The previous version of the FAQs has been removed from the Future NHS site.

What is the Joint Working Agreement?

On 2 February 2023, following the National Moderation Panel's assessment of system readiness against the Pre-Delegation Assessment Framework (PDAF), the NHS England Board approved the Panel's recommendations to delegate commissioning responsibility for 59 services to nine statutory joint committees, formed between NHS England and ICBs, from April 2023.

The nine joint commissioning footprints reflect the need to commission specialised services on a wider footprint formed of multiple ICBs which are broadly aligned to patient pathways and the flow of clinical activity into providers of services. To support establishment of joint commissioning arrangements, a template Joint Working Agreement has been made available for NHS England and ICBs.

The agreement sets out the arrangements that will apply between NHS England and the ICBs in relation to the joint commissioning of specialised services for the ICBs' populations – and the roles, responsibilities and functions each organisation is required to exercise. A statutory joint committee will then be established between the ICBs and NHS England to support arrangements from April 2023.

It is expected that joint commissioning arrangements will form part of a transition year in preparation for systems receiving delegated responsibility from April 2024.

Why are you using a Joint Working Agreement?

Section 65Z5 of the NHS Act 2006 (inserted by the Health and Care Act 2022) permits NHS organisations to enter joint working and delegated arrangements in respect of their statutory functions. The provisions provide new options for collaboration between NHS organisations. Whilst similar provisions have been adopted for some of NHS England's statutory functions in the past (for example, commissioning primary medical services), until now, specialised services were not included in these arrangements.

Joint exercise of statutory functions will have an impact on decision-making, responsibilities, and resourcing. Appropriate governance arrangements are therefore required and need to be designed, detailed, and established, including on finance responsibilities, contracting and the management and sharing of data. The Joint Working Agreement, supported by the establishment of statutory joint committees, is intended to formalise these arrangements, detailing the roles and responsibilities of NHS England and ICBs where the statutory functions will be jointly exercised in line with the NHS Act 2006.

Why is the Joint Working Agreement needed for specialised services?

The Roadmap for integrating specialised services within Integrated Care Systems, published in May 2022, presented the Joint Working Agreement as one of the key deliverables that will underpin the transition to delegation. This is because it provides an appropriate developmental step for ICBs to integrate commissioning of specialised services within their wider commissioning responsibilities.

The Joint Working Agreement enables ICBs greater opportunity to design and deliver specialised services, while at the same time retaining key features of the current model to provide ICBs enough developmental support prior to moving to statutory delegated commissioning arrangements from April 2024.

How is the Joint Working Agreement structured?

In addition to the general arrangements that will apply between NHS England and the ICBs in relation to the joint commissioning of specialised services for the ICBs' populations, there are nine further schedules covering:

- Definitions and interpretations (Schedule 1)
- Template terms of reference for a joint committee (Schedule 2)
- The list of services to be jointly exercised (Schedule 3)
- The list of functions to be jointly exercised (Schedule 4)
- The reserved (i.e., retained) services for NHS England (Schedule 5)
- The reserved (i.e., retained) functions for NHS England (Schedule 6)
- The scope for sharing information between NHS England the ICBs (Schedule 7)
- Applicable mandated guidance (Schedule 8)
- Local terms for capture within the Agreement (Schedule 9)

How should the Terms of Reference schedule be used?

This schedule provides a template describing the purpose, structure, and scope of the joint Committee. There are several provisions and guidance notes enabling NHS England regions and ICBs to adapt the Terms of Reference to meet local arrangements. The completed Terms of Reference are not required to be included in the Joint Working Agreement for signature, but they should be agreed at the first meeting of the Joint Committee.

How should the Local Terms schedule be used?

This schedule provides ICBs and NHS England with an opportunity to detail any additional local joint working arrangements within the Joint Working Agreement, for example around workforce or further governance arrangements, such as detailing sub-committees or sub-groups.

Who developed the Joint Working Agreement?

Development of the Joint Working Agreement has been co-ordinated by NHS England's national specialised commissioning strategy and policy team and the document has been drafted by legal services. It has involved extensive engagement and close collaboration with regional and national policy leads and subject matter experts. For example, an engagement process was undertaken between 17 October and 2 November 2022 where the draft Agreement was uploaded to the FutureNHS platform, alongside questions and FAQs, to enable wider system and regional involvement in developing the draft.

What is the difference between the Joint Working Agreement and the Delegation Agreement?

The Joint Working Agreement, supported by the establishment of statutory joint committees, is intended to formalise joint working arrangements, detailing the roles and responsibilities of NHS England and ICBs where the statutory functions will be jointly exercised. The Joint

Working Agreement is intended to bring together NHS England and multiple ICBs to jointly commission specialised services on a wider footprint.

A Delegation Agreement has also been developed and is being used for primary medical services, including medical, dental, ophthalmic, and pharmaceutical services. The Delegation Agreement is between NHS England and individual ICBs.

Can ICBs choose which services they will receive joint commissioning responsibility for?

No. NHS England's assessment of system readiness considers ICBs' ability to take on the services that were identified by the Service Portfolio Analysis as suitable and ready for greater ICB leadership from April 2023. There will not be an option to select a sub-set of services.

Are ICBs expected to be involved in services that they do not have joint commissioning responsibility for (i.e., NHS England retained services)?

To an extent, yes. The Joint Working Agreement sets out that joint committees will have a role in considering services that are 'suitable but not yet ready', as determined by the Service Portfolio Analysis. As these services remain the responsibility of NHS England however, it will have discretion as to which services are brought to the joint committee for involvement of ICBs. The ICB role will be akin to a 'seat at the table' and ICBs will have no formal decision-making power over these services. This approach ensures that these services still have the opportunity for more integrated design and delivery offered by joint working.

Do joint committees have to be set up to support Joint Working Agreements?

Yes. Joint committees will be the decision-making forum through which NHS England and ICBs will take collective responsibility for specialised commissioning statutory functions. This will enable both joint decision-making, and greater transparency and clarity of accountability for joint arrangements. Schedule 2 of the Joint Working Agreement includes terms of reference for the joint committee – while some of the terms are mandatory, the approach is generally permissive with significant scope for applicable terms to be agreed locally.

What financial responsibilities will ICBs entering joint working arrangements be expected to discharge?

In year one (2023/24), NHS England will hold the specialised commissioning budget and contracts. ICBs are not required to financially contribute to the specialised commissioning budget and there are no intentions to create a pooled fund or joint budget to support the Joint Working Agreement.

Through the Joint Working Agreement and joint committees, ICBs will have responsibility for supporting NHS England in its management of the specialised commissioning budget, ensuring proper financial governance, and supporting the move to population-based budgets.

What support is available to help NHS England regional colleagues and ICBs complete the Joint Working Agreement?

To support NHS England regional colleagues and ICBs in completing the final version of the JWA (version 4.0), the following resources have been developed:

- A guidance note, *Supporting information for completing the Joint Working Agreement (Specialised Commissioning)*, that provides further information on agreeing and signing the JWA, and is aligned to the guidance being prepared for completing the Delegation Agreement for primary care functions which will be released in due course.
- A session on joint working arrangements and the JWA recently recorded for the Specialised Services webinar series.
- Regional teams and ICBs are also reminded that the Safe Delegation Checklist is available to support the transition to joint committee arrangements.

If further support is required, please contact fcmp.england@nhs.net.

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Appendix Four: North West 'in scope' Specialised Commissioning Services

POC	Single ICS Footprint	Multi-ICS Footprint	NHS England Retained temporarily	NHS England Retained permanently
W&C	04A - Severe Endometriosis	13X - Adult CHD (Non Surgical)	04K - Complications of vaginal mesh	20A - Alkaptonuria (Adult)
W&C	04D - Urinary Incontinence/Genital Prolapse	13Y - Adult CHD (Surgical)	04L - Congenital Abmnormalities of Female Genital Tract	H23 - Alstrom Syndrome
W&C	23E - Paediatric Endocrinology & Diabetes	15Z - Cleft Lip and Palate	16Y - Immunology for Children with Immunodeficiency	23J - Ataxia Telangiectasia (Children)
W&C	NIC - Neonatal Critical Care	04C - Foetal Medicine	F23 - Perinatal Post Mortem & Pathology	16A - Autoimmune Paediatric Gut Syndrome
W&C		36Z - Metabolic Disorders	20H - Pre-Implantation Genetic Diagnosis	20B - Bardet Biedl Syndrome
W&C		23Y - Highly Specialist Paediatric Pain Mgmt		36A - Barth Syndrome
W&C		E23 - Highly Specialist Paediatric Palliative care		36B - Beckwith-Widemann Syndrome with Macroglossia
W&C		23B - Paediatric Cardiac Services		D23 - Bladder Exstrophy (Children)
W&C		23P - Paediatric Dental Surgery		K23 - Complex Childhood Osteogenesis Imperfecta
W&C		23D - Paediatric ENT		08A - Complex Neurofibramatosis Type 1
W&C		23F - Paediatric Gastro HPB and Nutrition		B23 - Complex Tracheal Disease
W&C		23Xb - Paediatric Gynae Surgery		N23 - Congenital Hyperinsulinism
W&C		23H - Paediatric Haematology Services		15A - Craniofacial
W&C		04G - Abnormally Invasive Placenta		29D - Primary Ciliary Dyskenesia (Diagnosis)
W&C		23M - Paediatric Neurosciences		R23 - ECMO (Respiratory - Neonates; Infants and Children)
W&C		07Y - Paediatric Neurorehabilitation		36F - CLN2 Disease
W&C		08J - Selective Dorsal Rhizotomy		36C - Lysosomal Storage Disorders
W&C		23Q - Paediatric Orthopaedics		26A - McArdles Disease
W&C		PIC - Paediatric Critical Care		20D - Mitochondrial Donation service
W&C		23R - Paediatric Plastic Surgery		08C - Neurofibramatosis Type 2
W&C		23S - Paediatric Renal Services		12B - Paediatric Intestinal Pseudo-Obstruction
W&C		23T - Paediatric Respiratory Services		13J - Paediatric Pulmonary Hypertension
W&C		23W - Paediatric Rheumatology Services		36D - Rare Mitochondrial Disorders
W&C		18C - Infectious Diseases (Children)		27D - Severe Acute Porphyria
W&C		23Xa - Specialist Paediatric General Surgery		08M - Spinal Muscular Atrophy
W&C		23Z - Paediatric Urology		43C - Inherited White Matter Disorders (Child)
W&C		35Z - Morbid Obesity (Children)		T23 - Multiple Sclerosis Mgmt for Children
W&C		04P - Complex Termination of Pregnancy		U23 - Open Foetal surgery to treat foetuses with Spina Bifida
W&C		17Zp - Specialist Allergy (Paed)		C23 - Specialist Paediatric Liver Disease
W&C				44A - Gonadal Tissue cryopreservation for CYP at high risk of gonadal failure due to treatment or disease
W&C				20C - Stickler Syndrome (Diagnosis)
W&C				A23 - Vein of Galen Malformation
W&C				Q23 - Wolfram Syndrome
W&C				04U - Uterine Transplantation
W&C				04J - Urinary Fistulae (Gynae)
W&C				29P - Primary Ciliary Dyskinesia Mgmt (Children)
W&C				73M - Childrens Epilepsy Surgery

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

POC	Single ICS Footprint	Multi-ICS Footprint	NHS England Retained temporarily	NHS England Retained permanently
Trauma	08O - Specialised Neurology	31Z - Highly Specialised Pain Management	05C - Specialised Communication Aids	08U - TcMRgFUS
Trauma	08P - Neurophysiology	37C - Artificial Eye Services	05E - Specialised Environmental Controls	37E - Limbal Cell (Holoclar) treatment for Eye Injuries
Trauma	08R - Neuroradiology	34R - Specialised Orthopaedic Revisions	06A - Spinal Cord Injuries	37D - Retinal Gene Therapy
Trauma	08S - Neurosurgery	32D - Middle Ear Implants		08B - Rare Neuromuscular Disords Diagnosis
Trauma	08T - Mechanical Thrombectomy	32A - Cochlear Implants		29F - ECMO (Respiratory - Adult)
Trauma	37Z - Specialised Opthalmology (Adult)	34T - Major Trauma (Paeds)		40A - Hand and Upper Limb Transplant
Trauma	34A - Specialised Orthopaedics (excl revisions)	08Y - Neuropsychiatry		08D - Neuromyelitis Optica
Trauma	32B - BAHAs	08F - Neurosurgical Low Vol Procedures (Regional)		01H - Ocular Oncology (Adult)
Trauma	06Z - Complex Spinal Surgery	08E - Neurosurgical Low Vol Procedures (Natl)		37A - Ophthalmic Pathology
Trauma	34T - Major Trauma (Adults)	23N - Specialised Opthalmology (Paed)		37B.- Osteo-Odonto Keratoprosthesis for corneal blindness
Trauma				32E - Auditory Brainstem Impants for Children
Trauma	07Z - Complex Rehabilitation			28Z - Hyperbaric Oxygen Therapy
Trauma	05P - Specialised Prosthetic Limbs			09A - Specialised Burns (Adult)
Trauma	ACC - Adult Critical Care			09C - Specialised Burns (Paed)
Trauma	08G - Neurosurgical Low Vol Procedures (Centres)			43A - Inherited White Matter Disorders (Adult)
Trauma				05V - Veterans Prosthetic Services
Trauma				

POC	Single ICS Footprint	Multi-ICS Footprint	NHS England Retained temporarily	NHS England Retained permanently
IM	29S - Severe Asthma	26Z - Adult Highly Specialist Rheumatology	10Z - Cystic Fibrosis	23G - Adult Ataxia Telangiectasia
IM	29M - Interstitial Lung Disease	27Z - Adult Specialist Endocrinology	12Z - Intestinal Failure	29G - Primary Ciliary Dyskinesia Mgmt (Adult)
IM	29A - Pulmonary Vascular Services	24Z - Specialised Dermatology	11T - Renal Transplant	11A - Atypical Haemolytic Uraemic Syndrome
IM	13C - Inherited Cardiac Conditions	01J - Anal Cancer	29V - Complex Home Ventilation	12A - Autologous Intestinal Reconstructn (Adult)
IM	13B - Cardiology (EP and Ablation)	01V - Biliary Tract Cancer	29E - Management of Central Airway Obstruction	16B - Behcets Syndrome (Adult & Adol)
IM	13H - Cardiac MRI	01W - Liver Cancer		29Q - Chronic Pulmonary Aspergillosis (Adult)
IM	13E / 13Z - Cardiac Surgery	19V - Pancreatic Cancer		M23 - Complex Ehlers Danlos Syndrome
IM	13A - Cardiology (Complex Device Therapy)	33D - Distal Sacrectomy for Advanced/Recurrent Rectal Cancer		11D - Encapsulating Peritoneal Sclerosis (Ad)
IM	13F - PPCI (for STEMI)			24A - Epidermolysis Bullosa
IM	13T - TAVI			13N - Heart & Lung Transplantation
IM	11C - Access for Renal Dialysis			13V - Ventricular Assist Devices
IM	11B - Renal Dialysis			43S - Stevens-Johnson Syndrome & Toxic Epidermal Necrosis
IM	30Z - Vascular			27A - Insulin Resistant Diabetes
IM	24Y - Skin Cancer			19A - Total Pancreatectomy with Islet Autotransplantat
IM	27E - Adrenal Cancer			27B - Islet Cell Transplant (Adult)
IM	33B - Complex Inflamatory Bowel Disease			19T - Liver Transplant
IM	33A - Faecal Incontinence			29C - Lymphangioleiomyomatosis (Adult)
IM	33C - Transanal Endoscopic Microsurgery			27C - Pancreas Transplant (Adult)
IM	19Z (inc 19L and 19P) - Complex Liver, Biliary and Pancreas			01F - Pseudomyxoma Peritonei (Adult)
IM				13M - Pulmonary Thromboendarterectomy
IM				12D - Small Bowel Transplant
IM				24D - DNA Nucleoside Excision Repair Disords
IM				39A - Gastroelectrical Stimulation for Intractable Gastroparesis
IM				33E - Cytoreductive surgery and HIPEC for Colorectal Cancer
IM				13G - Adult Pulmonary Hypertension
IM				29H - Alpha 1 Antitrypsin services
				36E - Cystinosis

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

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

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

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

30 March 2023

2022-2023 Emergency Preparedness, Resilience and Response Core Standards Assurance Report

Agenda Item No	**ICB/03/30/13**
Report author & contact details	Beth Warburton, Head of Emergency Preparedness, Resilience and Response
Report approved by (sponsoring Director)	Anthony Middleton, Director of Performance and Planning
Responsible Officer to take actions forward	Beth Warburton, Head of Emergency Preparedness, Resilience and Response

2022-2023 Emergency Preparedness, Resilience and Response Core Standards Assurance Report

Executive Summary	The purpose of this report is to provide the Integrated Care Board (ICB) Executive Team with the self-assessment against the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) and subsequent actions to improve compliance over the coming year.				
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 with assurance of delivery of actions and future improved compliance through the ICB EPRR governance structures.				
Key issues	Outlined within the report				
Key risks	None				
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				
Equality, Diversity and Inclusion	n/a				
Health inequalities	n/a				
Next Steps	Outlined within Appendix Three				
Appendices	**Appendix Three:** Statement of Compliance **Appendix Two:** ICB Compliance Breakdown **Appendix Three:** Action Plan				

2022-2023 Emergency Preparedness, Resilience and Response Core Standards Assurance Report

1. Executive Summary

1.1 The purpose of this report is to provide the Integrated Care Board (ICB) Executive Team with the self-assessment against the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) and subsequent actions to improve compliance over the coming year.

2. Introduction / Background

2.1 The Civil Contingencies Act (CCA) 2004 and the NHS Act 2006 as amended by the Health and Social Care Act 2022 underpin EPRR within health. Both Acts place EPRR duties on the NHS in England.

2.2 Under the CCA 2004, ICB's are Category 1 responders, which are recognised as being the core of emergency response and are subject to the full set of civil protection duties including risk assessment of emergencies, to have in place emergency plans and business continuity management arrangements and a requirement to share information and cooperate with other agencies.

2.3 In line with contractual requirements, Cheshire and Merseyside ICB were required to provide an annual assurance of compliance with the Core Standards, with a 2022-23 submission deadline of Friday 18 November 2022. This submission compromised of a Statement of Compliance, EPRR Core Standards Self-Assessment and associated action plan.

3. EPRR Core Standards Self-Assessment

3.1 There are 47 standards applicable to the Integrated Care Board which is self- assessed based on 4 levels of compliance.

Full	Substantial	Partial	Non-Compliant
Compliant with **all** standards	The organisation is **89-99%** compliant	The organisation is **77-88%** compliant	The organisation is compliant with **76% or less**

3.2 Based on Cheshire and Merseyside's self-assessment on Friday 28 November 2022; 28 standards were declared as full compliance, 24 standards were declared as partial compliance and 12 standards were declared as non-compliance, resulting in an overall EPRR compliance assurance rating of non-compliant (60%) for 2022/2023 (Appendix One). A breakdown of the ICB's full, partial, and non-compliant standards can be found in Appendix Two.

3.3 Cheshire and Merseyside ICB receiving a rating of non-compliant should not be perceived as a poor assurance rating as the EPRR Team are delivering against each NHS Core Standard for EPRR, following the ICB being a Category 1 responder from Friday 1 July 2022. However, it does indicate there are significant opportunities for the organisation to further improve over the coming year, through the implementation and monitoring of effective action plans as well as the recruitment of the EPRR Team.

3.4 Peer Reviews were undertaken with neighbouring ICB's as a benchmarking tool. Both Greater Manchester and Lancashire and South Cumbria ICB's also declared non-compliant for 2022/23.

3.5 Actions to address partial and non-compliant standards are in place and will be overseen by the Cheshire and Merseyside Local Health Resilience Partnership Strategic Group. The latest action plan can be found in Appendix Three.

3.6 In addition to the 47 EPRR Core Standards, a 'deep dive' is conducted each year on a different topic to gain additional assurance. 2022 'deep dive' was evacuation and shelter with 8 standards for the ICB to self-assess against. Please note, the 'deep dive' does not contribute to the overall Integrated Care Board compliance level.

4. Recommendations

4.1 The ICB Board are asked to note the contents of this report with assurance of delivery of actions and future improved compliance through the ICB EPRR governance structures.

5. Officer contact details for more information

Beth Warburton
Head of Emergency Preparedness, Resilience and Response
beth.warburton@cheshireandmerseyside.nhs.uk

Appendix One – Statement of Compliance

Cheshire and Merseyside ICB has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Cheshire and Merseyside ICB will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Non-compliant (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer
Anthony Middleton

30/03/2023 Date of Board	30/03/2023 Date presented at Public Board	01/07/2023 Date published in organisations Annual Report

Appendix Two – ICB Compliance Breakdown

Fully Compliant Standards		
Domain	**Standard Name**	**Standard Detail**
Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer responsible for EPRR. This individual should be a board level director within their individual organisation, and have the appropriate authority, resources, and budget to direct the EPRR portfolio.
	EPRR Board Reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements.
Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.
	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.
	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.
Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.
	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports and briefings during the response to incidents including bespoke or incident dependent formats.
Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership meetings.
	LRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum, demonstrating engagement and co-operation with partner responders.
	LHRP Secretariat	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership meets at least once every 6 months.

Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.

Partially Compliant Standards		
Domain	**Standard Name**	**Standard Detail**
Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's business objectives and processes, key suppliers and contractual arrangements, risk assessment(s) and functions and / or organisation, structural and staff changes.
	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.
	Continuous Improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.
Duty to risk assess	Risk Assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.
	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally.
Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.
	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic.
	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment.
Command and Control	On-Call Mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.

	Trained On-Call Staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions.
Training and Exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.
	Responder Training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role.
Response	Incident Coordination Centre	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards.
	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).
	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24-hour access to a trained loggist(s) to ensure support to the decision maker
Warning and Informing	Warning and Informing	The organisation aligns communications planning and activity with the organisation’s EPRR planning and activity.
	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.
	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.

	Media Strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media.
Cooperation	Information Sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.
Business Continuity	BC Policy Statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.
	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.
	Business Continuity Plans	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover, and manage its services during disruptions to people, information and data, premises, suppliers and contractors and IT and infrastructure.
	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured, and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.

Non-Compliant Standards		
Domain	**Standard Name**	**Standard Detail**
Governance	EPRR Work Programme	The organisation has an annual EPRR work programme, informed by current guidance and good practice, lessons identified from incidents and exercises, identified risks and outcomes of any assurance and audit processes. The work programme should be regularly reported upon and shared with partners where appropriate.
	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.

Duty to maintain plans	Evacuation and Shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff, and visitors.
Training and Exercising	EPRR Exercising and Training programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)
	Staff Awareness and Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.
Cooperation	Mutual Aid Arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.
	Arrangements for multi-area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.
Business Continuity	Business Impact Analysis	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).
	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.
	BC Audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.
	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.
	Assurance of commissioned providers / suppliers BCP's	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.

Appendix Three – Action Plan

Standard	RAG Status	Action to be taken	Lead	Timescale	Progress Update
EPRR Policy Statement The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes	Partially Compliant	EPRR Policy to be reviewed, updated and signed off On-Call Pack to be updated	Beth Warburton, Head of EPRR	28/04/2023	In progress and expected to be complete by deadline
Continuous Improvement The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.					
On-Call Mechanism The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.					
EPRR Work Programme The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Not Compliant	Annual EPRR work programme to be devised and shared with partners	Beth Warburton, Head of EPRR	31/03/2023	In progress and expected to be complete by deadline

EPRR Resources The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Partially Compliant	Recruitment of the ICB EPRR Team	Beth Warburton, Head of EPRR	31/05/2023	EPRR recruitment complete. EPRR Team to be fully resourced by end of May 2023
Risk Assessment The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Partially Compliant	Risk assessment process to be implemented for EPRR	Beth Warburton, Head of EPRR	31/08/2023	In progress and expected to be complete by deadline
Risk Management The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally.	Partially Compliant	Risk Management Strategy to be reviewed and signed off	Dawn Boyer, Assistant Director – Corporate Services	28/04/2023	In progress and expected to be complete by deadline
Adverse Weather In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Partially Compliant	Adverse Weather Plan to be produced	Beth Warburton, Head of EPRR	30/06/2023	Draft plan produced and expected to be complete for deadline
New and Emerging Pandemics In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic.	Partially Compliant	Pandemic Plan to be produced	Beth Warburton, Head of EPRR	31/07/2023	Draft plan produced and expected to be complete for deadline Exercise being held on 26/04/2023 to test the NW Outbreak Plan
Countermeasures In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment.	Partially Compliant	Countermeasure arrangements to be established and documented	Beth Warburton, Head of EPRR	29/09/2023	Not yet started - expected to be completed by deadline

Mass Casualty In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Not Compliant	Mass casualty arrangements to be added to the Incident Response Plan	Beth Warburton, Head of EPRR	30/06/2023	Not yet started - expected to be completed by deadline
Evacuation and Shelter In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff, and visitors.	Not Compliant	Evacuation and shelter arrangements to be established	Beth Warburton, Head of EPRR	31/07/2023	Draft plan produced and expected to be complete for deadline
Trained On-Call Staff Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions.	Partially Compliant	EPRR Policy to be reviewed, updated, and signed off	Beth Warburton, Head of EPRR	28/04/2023	In progress and expected to be complete for deadline
EPRR Training The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Partially Compliant	CPD portfolios to be produced for all on-call members of staff	Beth Warburton, Head of EPRR	31/08/2023	Not yet started - expected to be completed by deadline
Responder Training The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role.					
EPRR Exercising and Testing Programme In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely test incident response arrangements.	Not Compliant	Training and Exercising Programme to be produced	Beth Warburton, Head of EPRR	31/03/2023	In progress and expected to be complete for deadline
Staff Awareness and Training There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Not Compliant	Report to the Board on Exercise and Training attendance	Beth Warburton, Head of EPRR	31/08/2023	Not yet started - Expected to be completed by deadline

Incident Coordination Centre The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Partially Compliant	ICC audits to be undertaken monthly ICC SOP to be produced	Beth Warburton, Head of EPRR	30/06/2023	In progress and expected to be complete for deadline
Decision Logging To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24-hour access to a trained loggist(s) to ensure support to the decision maker	Partially Compliant	Loggist training to be delivered List of trained Loggists to be added to Resilience Direct	Beth Warburton, Head of EPRR	28/02/2023	Completed Loggist Training will continue to be delivered as part of the Training and Exercising Programme
Warning and Informing The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.		Deliver training / awareness sessions to on-call Communications	Beth Warburton, Head of EPRR	31/08/2023	Not yet started - Expected to be completed by deadline

Incident Communication Plan The organisation has a plan in place for communicating during an incident which can be enacted.	Partially Compliant	Media Protocol, Social Media Policy, and Incident Response Communications Plan to be signed off	Comms Team	31/07/2023	In progress and expected to be complete for deadline
Communication with Partners and Stakeholders The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident, or business continuity incident.					
Media Strategy The organisation has arrangements in place to enable rapid and structured communication via the media and social media.					
Mutual Aid Arrangements The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating, and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Partially Compliant	Incident Response Plan to be updated to include mutual aid arrangements and information sharing with stakeholders / partners during an incident	Beth Warburton, Head of EPRR	30/06/2023	Not yet started - Expected to be completed by deadline
Arrangements for Multi-Area Response The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.					
Information Sharing The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.					

Management of Business Continuity Incidents In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Partially Compliant	Business Continuity Policy to be reviewed, updated, and signed off Business Continuity Plan to be to be reviewed, updated, and signed off	Beth Warburton, Head of EPRR	30/09/2023	In progress and expected to be complete for deadline
BC policy statement The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.					
Business Continuity Management Systems (BCMS) scope and objectives The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.					
Business Impact Analysis / Assessment The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Not Compliant	Conduct a Business Impact Analysis for the ICB	Beth Warburton, Head of EPRR	31/05/2023	Not yet started - Expected to be completed by deadline
Business Continuity Plans The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover, and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Partially Compliant	ICB Business Continuity Plan template to be produced and shared	Beth Warburton, Head of EPRR	30/06/2023	Not yet started - Expected to be completed by deadline

Testing and Exercising The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Not Compliant	Testing and Exercising Schedule of Business Continuity Plans to be produced	Beth Warburton, Head of EPRR	31/08/2023	Not yet started - Expected to be completed by deadline
Business Continuity Management System Monitoring and Evaluation The organisation's BCMS is monitored, measured, and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Partially Compliant	BCMS monitoring and evaluation process to be developed	Beth Warburton, Head of EPRR	31/07/2023	Not yet started - Expected to be completed by deadline
Business Continuity Audit The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Not Compliant	Process for internal business continuity auditing to be developed	Beth Warburton, Head of EPRR	31/08/2023	Not yet started - Expected to be completed by deadline
Business Continuity Management System Improvement Process There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Not Compliant	BCMS continuous improvement process to be developed and documented within ICB Business Continuity Policy	Beth Warburton, Head of EPRR	30/09/2023	Not yet started - Expected to be completed by deadline
Assurance of commissioned providers / suppliers BCPs The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Not Compliant	System to assess the BCP's of commissioned providers or suppliers to be produced and included in Business Continuity Policy	Beth Warburton, Head of EPRR	31/03/2023	In progress and expected to be complete for deadline

NHS
Cheshire and Merseyside

People Board update to the ICB

Colin Scales, Chair of the C&M People Board
Christine Samosa, Chief People Officer, C&M ICB

Progress since last Board update

Terms of reference for People Board refreshed :

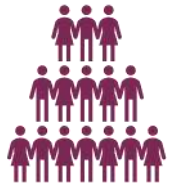
- Membership extended to include provider collaboratives, place representative, social care provider, AHP representative and voluntary sector
- Establishment of 3 sub committees (Workforce supply, workforce and operational planning and Primary Care workforce)

New work programmes include:

- Collaborative bank for health care support workers
- Allied health prevention faculty development
- Workforce planning for the Elective Recovery Programme
- Development of the ward based nurse role to aid retention
- Racialised trauma training
- Social prescribing for community workers
- Social care training needs analysis with Skills for Care

Key Workforce Headlines (Sources: Monthly Provider Workforce Returns (Nov-22), Model Health System)

NHS Cheshire and Merseyside



- From August to November 2022, the total substantive workforce in secondary care in Cheshire & Merseyside grew by 2.3% (69,063 WTE in Aug-22, compared to 70,652 WTE in Nov-22, an increase of +1,589 WTE)
- All major staff groups have seen an increase in numbers during the period
- During the same period, the total Primary Care workforce grew by +28 WTE/+0.4%, to 6,762 WTE
- Bank and Agency usage has increased during the period; Bank by +26.7 WTE/+0.4%, Agency by +151.7 WTE/+6.7%.
- During the period, the total vacancy rate fell from 7.7% to 6.8% (all staff group total)
- The turnover rate fell from 2.8% in Aug-22 to 0.9% in Nov-22 (all staff group total)
- Total sickness rates have increased; from 5.5% in Aug-22, to 5.9% in Nov-22

- 104-week waits have reduced significantly in the period Aug-22 to Nov-22; from 60 to 26, a reduction of -56.7% (for surgical pathways)
- 52-week waits (surgical pathways) have decreased slightly during the same period; 24,599 in Aug-22 to 24,485 in Aug-22, a decrease of -0.5%
- The number of patients (per 100,000 population) waiting for any of the 15 diagnostic tests and procedures included in the diagnostic waiting times monthly data collection increased in the period from Aug-22 to Nov-22. In Aug-22, the diagnostic waiting list was 2584 per 100,000, whereas in Nov-22, this figure stood at 2626; an increase of +1.6%

Staff Growth & Activity Breakdown

(Sources: Monthly Provider Workforce Returns (Nov-22), Model Health System)

NHS Cheshire and Merseyside

Total Workforce (Substantive + Bank + Agency) as at November 2022:
79,780.8 WTE

Total Bank Nov-22:

6717.8 WTE

Bank Growth Aug-22 to Nov-22:

+26.7/+0.4%

% of Total Workforce that is Bank (Nov-22):

8.4%

Total Agency Nov-22:

2401.4 WTE

Agency Growth Aug-22 to Nov-22:

+151.7/+6.7%

% of Total Workforce that is Agency (Nov-22):

3%

Bank and Agency as a proportion of total workforce increase Aug-22 to Nov-22:
10.1%

Vacancy rate change Aug-22 to Nov-22:
-0.9%

104-Week Waits:

-34/-56.7% (Aug-22 to Nov-22)

52-Week Waits:

-114/-0.5% (Aug-22 to Nov-22)

Diagnostic Waiting List (per 100,000):

+42/+1.6% (Aug-22 to Nov-22)

UEC Attendances:

-6.7% below same month in previous year (19/01/23)

Staff Group Growth Breakdown (Source: Monthly Provider Workforce Returns – Aug to Nov 2022)

NHS Cheshire and Merseyside

Substantive WTE	Aug-22	Nov-22	Difference +/-	% +/-
Administrative & Clerical	18,636.0	18,868.0	232.0	1.2%
Allied Health Professionals	5,065.6	5,206.8	141.2	2.8%
Healthcare Scientists	1,306.7	1,325.3	18.6	1.4%
Medical & Dental	6,679.3	6,787.3	108.0	1.6%
Nursing & Midwifery	20,426.0	21,062.0	636.0	3.1%
Other Scientific, Therapeutic and Technical Staff	2,312.9	2,377.4	64.5	2.8%
Support to Clinical	14,637.0	15,025.0	388.0	2.7%
Total Substantive	69,063.5	70,651.8	1588.3	2.3%

Bank WTE	Aug-22	Nov-22	Difference +/-	% +/-
Administrative & Clerical	970.8	1,031.1	60.3	6.2%
Allied Health Professionals	84.9	73.8	-11.1	-13.1%
Medical & Dental	537.8	645.7	107.9	20.1%
Nursing & Midwifery	1,814.4	1,894.8	80.4	4.4%
Support to Clinical	3,283.2	3,072.4	-210.8	0.0%
Total Bank	6,691.1	6,717.8	26.7	0.4%

Agency WTE	Aug-22	Nov-22	Difference +/-	% +/-
Administrative & Clerical	246.4	231.5	-14.9	-6.0%
Allied Health Professionals	167.5	184.9	17.4	10.4%
Medical & Dental	485.1	570.7	85.6	17.6%
Nursing & Midwifery	874.6	926.7	52.1	6.0%
Support to Clinical	476.1	487.6	11.5	0.0%
Total Agency	2,249.7	2,401.4	151.7	6.7%

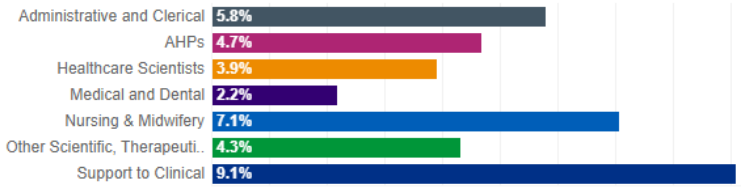
During the period Aug-22 to Nov-22, all staff groups saw an increase in substantive staff, the highest percentage increase being in Nursing & Midwifery staff (+3.1%) Two staff groups saw a decrease in Bank and Agency numbers (AHPs -13.1% Bank, and Admin & Clerical -6.0% Agency)

Sickness, Turnover & Vacancies – Secondary Care

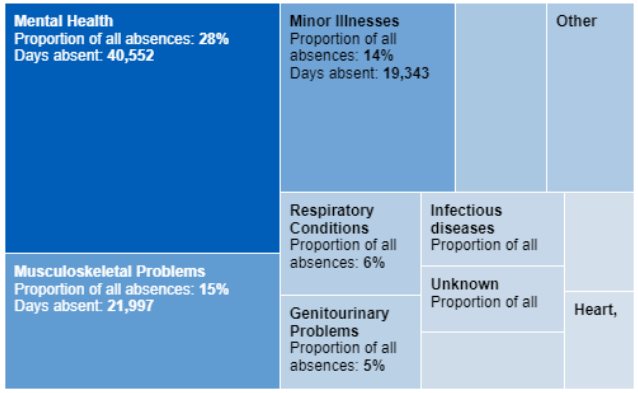
NHS Cheshire and Merseyside

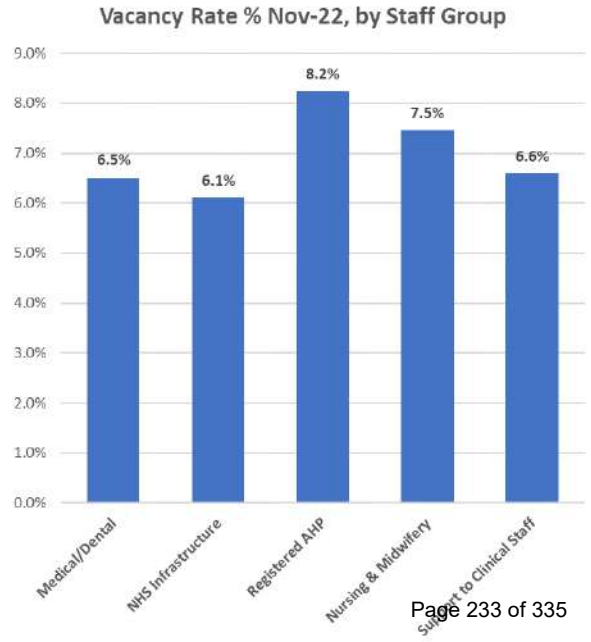
Trust	Sickness Rate			Turnover Rate			Vacancy Rate		
	Aug-22 %	Nov-22 %	Trend	Aug-22 %	Nov-22 %	Trend	Aug-22 %	Nov-22 %	Trend
Alder Hey Children's NHS Foundation Trust	5.9%	6.5%	HIGHER	2.1%	1.0%	LOWER	3.4%	0.0%	LOWER
Bridgewater Community Healthcare NHS Foundation Trust	5.3%	6.1%	HIGHER	1.2%	0.7%	LOWER	10.3%	10.0%	LOWER
Cheshire and Wirral Partnership NHS Foundation Trust	6.1%	6.7%	HIGHER	1.3%	1.3%	SAME	9.2%	9.2%	LOWER
Countess of Chester NHS Foundation Trust	5.6%	5.1%	LOWER	2.0%	0.5%	LOWER	10.2%	9.9%	LOWER
East Cheshire NHS Trust	5.5%	5.8%	HIGHER	0.9%	0.6%	LOWER	9.1%	7.3%	LOWER
Liverpool Heart and Chest Hospital NHS Foundation Trust	5.2%	5.5%	HIGHER	1.7%	1.1%	LOWER	3.1%	3.4%	HIGHER
Liverpool University Hospitals NHS Foundation Trust	6.1%	6.8%	HIGHER	2.0%	0.9%	LOWER	7.7%	6.6%	LOWER
Liverpool Women's NHS Foundation Trust	7.6%	7.4%	LOWER	1.2%	0.8%	LOWER	11.0%	8.9%	LOWER
Mersey Care NHS Foundation Trust	8.0%	8.1%	HIGHER	1.2%	0.8%	LOWER	5.7%	6.0%	HIGHER
Mid Cheshire Hospitals NHS Foundation Trust	5.3%	5.4%	HIGHER	1.1%	0.6%	LOWER	12.1%	10.2%	LOWER
Southport and Ormskirk Hospital NHS Trust	6.0%	6.8%	HIGHER	2.1%	1.1%	LOWER	10.8%	8.9%	LOWER
St. Helens and Knowsley Teaching Hospitals NHS Trust	3.3%	3.5%	HIGHER	7.2%	1.0%	LOWER	7.1%	5.7%	LOWER
The Clatterbridge Cancer Centre NHS Foundation Trust	5.3%	5.4%	HIGHER	1.2%	0.8%	LOWER	8.0%	7.3%	LOWER
The Walton Centre NHS Foundation Trust	5.6%	6.2%	HIGHER	2.6%	1.1%	LOWER	5.4%	3.9%	LOWER
Warrington and Halton Teaching Hospitals NHS Foundation Trust	5.5%	5.8%	HIGHER	2.3%	0.8%	LOWER	11.9%	11.8%	LOWER
Wirral Community Health and Care NHS Foundation Trust	6.7%	7.0%	HIGHER	1.3%	0.8%	LOWER	5.6%	5.1%	LOWER
Wirral University Teaching Hospital NHS Foundation Trust	5.9%	6.5%	HIGHER	1.9%	1.1%	LOWER	4.0%	3.4%	LOWER
C&M AVERAGE	5.5%	5.9%	HIGHER	2.8%	0.9%	LOWER	7.7%	6.8%	LOWER

Sickness Absence Rate by Staff Group | November 2022 |



Reasons for sickness absence | November 2022 |





Key insights:

- The average sickness rate across Cheshire & Merseyside was 5.9% in Nov-22.
- Two of the 17 C&M trusts had a vacancy rate that had increased from the level of previous quarter. The average vacancy rate across all trusts in Sep-22 was 7.7%(all staff groups)
- The highest vacancy rate in Nov-22 was for AHPs, at 8.2%
- The highest sickness rate by staff group was for Support to Clinical staff, at 9.1%

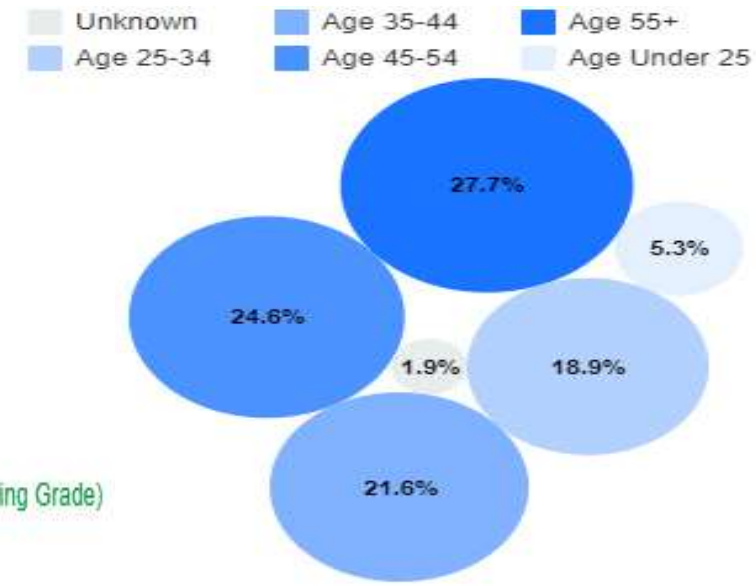
Source: ESR via eProduct – Workforce: Secondary Care (Nov 2022). Vacancy and turnover rates from PWRs/NWID

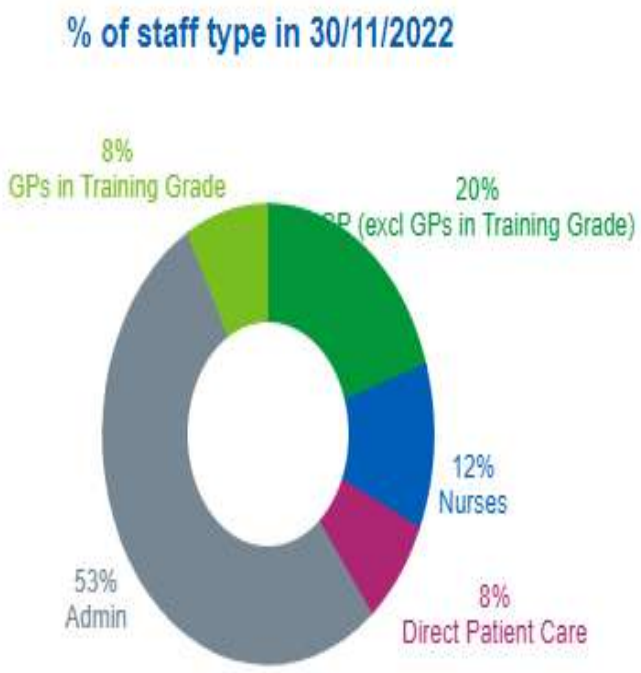
Primary Care/Social Care

NHS Cheshire and Merseyside

Primary Care – November 2022

GP (excl GPs in Training Gr..	GPs in Training Grade	Nurses	Direct Patient Care	Admin	Grand Total
1,363	542	784	511	3,562	6,762





Social Care – 2020/21

70,000 jobs

in the **local authority and independent sector.**

18% of jobs were **zero-hours contracts**.

6.0% average **vacancy rate** in 2020/21.

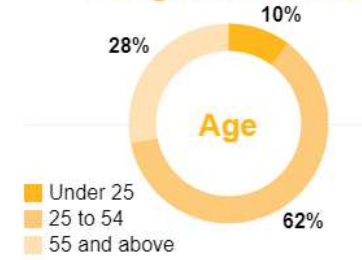
The average **turnover rate** was **27.5%**

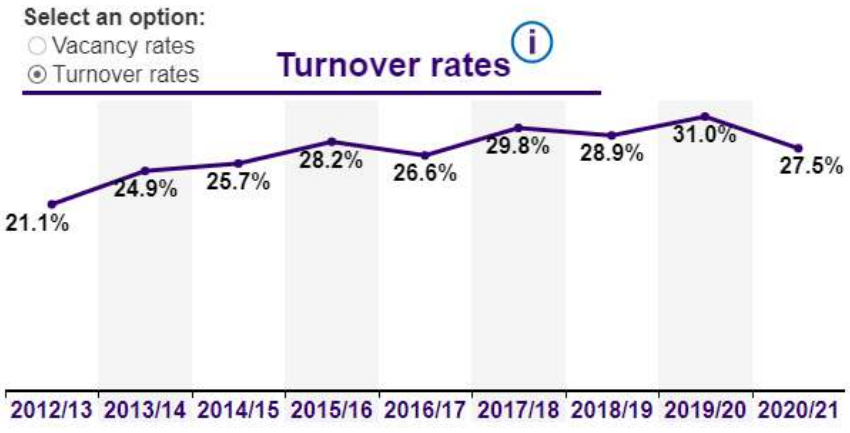
28% were **aged 55 or above**.

80% of the workforce were **female**.

The average **age** was **44 years old**

20% of the workforce were **male**.





Source: Primary Care - NWRS via eProduct – Workforce: Primary Care (Nov 2022). Social Care data from Skills for Care

Strategic Workforce model

nationally prescribed outcomes-based functions of ICS People Boards

1. Supporting the **health and wellbeing** of all staff: people working and learning across the ICS feel safe and supported in their physical and mental health and wellbeing, and are therefore better able to provide high-quality, compassionate and culturally competent care to patients.
2. **Growing the workforce for the future** and enabling adequate **workforce supply**: the system is **retaining**, **recruiting** and, where required, **growing its workforce** to meet future need. The 'one workforce' across the ICS is representative of the rich diversity of the UK and has a clear ethical ambition for the integration of an international workforce in stabilising workforce supply across health and care.
3. Supporting **inclusion and belonging** for all, and creating a **great experience** for staff: people working and learning across the ICS can develop and thrive in a compassionate, culturally competent and inclusive environment. Issues of inequality and inequity are identified and addressed for all people working in the system. The workforce and leaders in the ICS are representative of the diverse populations they serve.
4. Valuing and supporting inclusive compassionate systems **leadership** at all levels through lifelong learning: leaders at every level live the behaviours and values set out in the People Promise, and possess the necessary competence and capability to lead for the improved health outcomes, closing the gap on health inequalities, achieving best value and driving social value activity to support the wider determinants of health
5. Leading **workforce transformation** and new ways of working: service redesign is enabled through new ways of working, which make the most of staff skills, use of technology and wider innovation – to both meet population health needs and drive efficiency and value for money.

6. **Educating, training and developing** people, and **managing talent**: education and training plans and opportunities are aligned and fit for purpose to respond to a changing health and care demographic. The needs of staff, patients and citizens are used to develop learning solutions to support treatment, prevention and health creation, including to enable new ways of working that support meaningful and inclusive personalised career journeys

7. Driving and supporting **broader social and economic development**: leaders ensure that their organisations leverage their role as anchor institutions and networks to create a vibrant local labour market, promote local social and economic growth in the wider community, support all ICS partners to 'level up', address wider health determinants and inequalities at the heart of poor health.

8. **Transforming people services** and supporting the people profession: high quality people services are delivered by a highly skilled people profession to meet the future needs of the 'one workforce', enabled by technology infrastructure and digital tools.

9. Leading coordinated **workforce planning** using analysis and intelligence: integrated and dynamic workforce, activity and finance planning meets current and future population, service and workforce needs, across programme, pathway and place.

10. Supporting **system design and development**: the system deploys specialist OD principles and system design methodologies / approaches to support the ICB and ICS to respond to the HCA, 2022 'statutory duty to collaborate' in service of improved health outcomes for all. OD is deployed as a critical enabler of cultural systems transformation towards engineering new sustainable ways of working across health and care partners with a lens on human dynamics.

Workforce priorities for 2022- 2027

NHS
Cheshire and Merseyside

System wide workforce planning

Ensuring a health and care workforce that is fit for the future

Smarter workforce planning linked to population health need

Creation of a 5,10 and 15 year integrated workforce plan

Developing a greater triangulation between workforce/productivity / activity / finance

Creating new opportunities

Grow our own future workforce

Increased focus on apprenticeships

New roles responsive to population health need

Review of barriers to recruitment

Work with the further and higher education sector

PCN Development

Greater links with social care and primary care

Ensuring an effective student experience

Promoting health and wellbeing

Ensuring appropriate physical and mental health and wellbeing support for all staff

Focus on retention

Preventing burnout

Ensuring appropriate supervision and preceptorship is available

Using population health data to develop responsive and pro-active solutions to workforce health and wellbeing

Maximising and valuing the skills of our staff

Impact of 5 generations working together/ changing expectation of the workforce

Developing flexible career options at different stages of our lives and across health and social care

Responding to reviews and recommendations in a positive manner

Creating a positive and inclusive culture

Proactive support of inclusion and diversity as a priority

Responding to the needs of staff with protected characteristics to create inclusive working practices

Culturally competent inclusive system leadership

Development of learning and restorative practices

System wide workforce planning

Ensuring a health and care workforce that is fit for the future

Smarter workforce planning linked to population health nee

Creation of a 5,10 and 15 year integrated workforce plan

Developing a greater triangulation between workforce/productivity / activit / finance

Actions to address this priority

- Development of agreed workforce dashboard to be developed and shared with Providers and Places
- Assessment of workforce planning capacity and capability across providers and development of appropriate training
- Research into population health need to inform workforce planning methodology
- Development of annual workforce plan (NHS) in line with operating planning process /Development of agreed 5 and 10 year costed workforce plan
- Develop an agreed methodology for determining workforce productivity for NHS providers
- Develop a system wide talent management and succession planning strategy that is responsive to critical workforce gaps

Creating new opportunities

Grow our own future workforce

Increased focus on apprenticeships

New roles responsive to population health need

Review of barriers to recruitment

Work with the further and higher education sector

PCN Development

Greater links with social care and primary care

Ensuring an effective student experience

Actions to address this priority

- Understand national initiatives and new roles being developed
- Develop a Cheshire and Merseyside Apprenticeship strategy and associated implementation plan
- Establish a task and finish group to explore the barriers to recruitment including the application and interview process for new entrants . Review time to hire data and share best practice. Work with the provider collaboratives to co-ordinate collaborative recruitment programmes
- Work with the Health and care academies , further and higher education sectors to explore collaborative development opportunities for non degree level entry roles
- Explore opportunities for collaborative development of staff across health and social care for both registered and non registered workforce and develop appropriate business cases for consideration Explore greater cross movement of health and social care staff and opportunities for rotation, shared development and clinical supervision
- In partnership with the Primary Care teams develop appropriate development programmes and explore opportunities for greater collaboration
- Monitor student experience data and ensure that learning is shared – develop preceptorship offer for newly qualified staff
- Promotion of the range of careers in health and social care for local communities which will impact on health inequalities
- Develop ethical and sustainable approach to international recruitment

Promoting health and wellbeing

Ensuring appropriate physical and mental health and wellbeing support for all staff

Focus on retention

Preventing burnout

Ensuring appropriate supervision and preceptorship is available

Using population health data to develop responsive and pro-active solutions to workforce health and wellbeing

Actions to address this priority

- Undertake a stocktake of all health and wellbeing initiatives across C&M, including primary care and social care including the current mental health resilience hub
- Roll out of the Grow Occupation Health initiative
- Develop a best practice guide for providers with a suite of resources to support staff (financial support, mental health support , relationship support, domestic violence programme
- Further develop the work of the retention lead to cover all staff groups, sharing best practice, utilising the national tools and share the learning with social care and primary care (via the training hubs)
- Roll out of legacy mentor schemes
- Build on the preceptorship work undertaken by the Director of Nursing in 2021/21 and share best practice across other disciplines .
- Provider regular retention data and improvement trajectories
- Map population health demographics to anticipate workforce health and wellbeing strategies that a re future proof i.e. increase in mental health and MSK

Maximising and valuing the skills of our staff

Impact of 5 generations working together/ changing expectation of the workforce

Developing flexible career options at different stages of our lives and across health and social care

Responding to reviews and recommendations in a positive manner

Actions to address this priority

- Undertake research into the work and career aspirations of staff at varying stages in their careers and develop leadership programmes to recognise the change.
- Review shift and working patterns and make recommendations on suggested improvements which will meet the needs of staff and ensure a sustainable and committed workforce/ review e rostering systems and undertake analysis of flexible working patterns and requests across all health and care sectors
- Develop career 'escalators' and 'elevators' that will support staff in career choices across health and social care (by May 2024) and allow greater flexibility in working hours/ cross organisational working etc
- Support the development of health and care academies / healthcare support worker academies
- Share data/ dashboard on use of bank and agency staff , vacancy data to demonstrate changes in how workforce is made up
- Explore role hybridity across sectors that attends to the interdependencies between care pathways

Creating a positive and inclusive culture

Proactive support of inclusion and diversity as a priority

Responding to the needs of staff with protected characteristics to create inclusive working practices

Culturally competent inclusive system leadership

Development of learning and restorative practices

Actions to address this priority

- Develop a system wide EDI strategy with clear objectives based on system WRES and WDES data/ Gender pay gap data / EDS2 feedback etc in line with the national strategy (by October 2023)
- Develop and implement an agreed cultural competency framework across Cheshire and Merseyside (by January 2024)
- Understand the perception of Cheshire and Merseyside as a safe place to work for those with protected characteristics from staff survey data and exit data (by April 2024)
- Create appropriate system wide staff networks and support mechanisms for staff with appropriate advocacy and professional support (by April 2024)
- Community engagement to understand barriers for those with protected characteristics coming into the health and care sector in Cheshire and Merseyside
- Unlock the potential for diversity and lived experience in improving health outcomes

Next steps

- Establishment of sub committees
- Workshop planned for May 2023 to consider system challenges and priorities
- Consideration of workforce submissions from the operational planning round
- Continue to support work with Skills for Care and ADASS to develop place based social care workforce plans
- Development of data dashboard

Thank you

Any questions?

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

30 March 2023

ICB Staff Survey 2022: Results & Actions

Agenda Item No	**ICB/03/30/15**
Report author & contact details	Vicki Wilson, Associate Director of Workforce Vicki.Wilson@cheshireandmerseyside.nhs.uk Suzanne Burrage, Head of Staff Experience, Engagement and Wellbeing (internal) Suzanne.burrage@cheshireandmerseyside.nhs.uk
Report approved by (sponsoring Director)	Chris Samosa, Chief People Officer
Responsible Officer to take actions forward	Suzanne Burrage, Head of Staff Experience, Engagement and Wellbeing

ICB Staff Survey 2022: Results and Actions

Executive Summary	This paper (and supporting presentation) provides an overview of the ICB staff survey results for 2022. The results are presented against the 7 areas of the national People Promise and the key themes of staff engagement and morale. The presentation and report also provides an overview of activity to date in respect of sharing the survey results with staff, their feedback in regard to the emerging themes and the development of resultant action areas. The presentation also provides a high-level overview of the staff engagement scores for organisations across the Cheshire & Merseyside system with identification in movement from the previous survey year. Organisations are currently sharing their own results and developing localised action plans in line with staff feedback. Further overview of system results will be discussed at the April meeting of the Board.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X				X
Recommendation	**The Board is asked to:** • **note** the ICB staff survey results and **endorse** the actions taken to review, disseminate and respond to the Staff Survey results 2022.				
Key issues	The ICB results are detailed in the attached staff survey presentation. At a high level, the ICB staff engagement score is 6.72 and staff morale is 5.73. Following a review of the results and comparison to other peer group organisations, the ICB scored positively in the following areas: • Interpersonal relationships within teams including interactions within teams, kindness and understanding shown at team level and handling of local disagreements • Lower instances than in comparative sectors in relation to Discrimination, Bullying and Harassment and Physical violence. Following this review and comparison, the following key areas for improvement and ongoing development were identified: • Celebration and Recognition – congratulation to individuals and teams, feeling valued at work, respecting individual differences, celebrating success, constructive feedback • Health & Wellbeing of Staff – creating a positive climate, taking positive action, raising awareness of what is available				

<table>
<tr><td></td><td>

Retention of Staff – having the conversation early, a robust approach to staff feedback
Learning – effective appraisal system, opportunity to develop career
Capacity to undertake role – managing time pressures, having enough staff, avoiding duplication and duel running
Motivation at Work – understanding personal responsibilities, ability to influence and be involved in change at work, looking forward to work and recommendation of the ICB as a place to work.

172 narrative free text comments were also submitted from staff in support of the structured questions within the survey. We have conducted a thematic review of the feedback with key themes emerging around:

Organisational Restructure and change leading to concerns in respect of job security
Connection and engagement with Leaders across the ICB
Staff Morale impacted by factors both internal to the ICB and within the NHS
Work Environment in terms of balance of agile working and opportunities for face-to-face interactions.

Following the initial sharing of our results (under embargo conditions), a meeting of representatives from all teams across the ICB was held on 20th February 2023. This Staff Survey engagement forum met to undertake a collaborative review of the findings, explore any themes, identify areas for action and agree on going dissemination and engagement across the ICB. A dedicated session of We Are One was held on 15 March 2023 to share the results widely and engage with staff to help inform areas of improvement and plans for future engagement. This session also utilised an interactive engagement tool to ask for staff feedback across areas including reward and recognition, staff engagement, health & wellbeing, and leadership. A detailed report of this session and feedback was shared as part of the following weekly bulletin.
</td></tr>
<tr><td>Key risks</td><td>Staff morale and productivity.</td></tr>
<tr><td>Impact (x)
(further detail to be provided in body of paper)</td><td>
<table>
<tr><th>Financial</th><th>IM &T</th><th>Workforce</th><th>Estate</th></tr>
<tr><td></td><td></td><td>X</td><td></td></tr>
<tr><th>Legal</th><th>Health Inequalities</th><th>EDI</th><th>Sustainability</th></tr>
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</td></tr>
<tr><td>Route to this meeting</td><td>A presentation was delivered to the Executive Team on 9th March by our independent survey provider. This was supported by the establishment of a Staff Survey Engagement Forum (consisting of representatives of all ICB corporate and place teams) to share the headline results, discuss potential areas of improvement and ongoing handling and engagement across ICB teams. A dedicated session of We Are One was held on 15th March to share the results and engage with staff to help inform areas of improvement and plans for future engagement.</td></tr>
</table>

Management of Conflicts of Interest	No conflicts of interest identified.	
Patient and Public Engagement	Not applicable to the content of this paper.	
Equality, Diversity, and Inclusion	The Nature of this paper as a position statement on the results of the staff survey does not require an Equalities Health Impact Assessment (EHIA) to be undertaken. However, the survey results will be subject to further detailed review and assessment in line with the Equality Delivery System by the new Associate Director of Equality, Diversity & Inclusion in April.	
Health inequalities	Not Applicable to the contents of this paper.	
Next Steps	• Collation of all localised feedback from members of the Staff Survey Engagement Forum and We Are One Session to inform the priorities of the Staff Survey Action Plan • Publish the staff survey action plan in early April 2023 • Assurance reporting to the Finance & Investment Committee on 25th April • Launch of a new ICB Staff Engagement Group in April 2023 as part of a proposed integrated internal communications and staff engagement framework • Further analysis as more benchmarking information becomes available and areas for ongoing review and deep dive are identified. • Establishment of a new People Committee to provide assurance in respect of the internal people agenda.	
Appendices	**Appendix One**	Staff Survey Results 2022 & Action Areas

ICB Staff Survey 2022-23: Results and Actions

1. Executive Summary

1.1 This paper (and supporting presentation) provides an overview of the ICB staff survey results for 2022. The results are presented against the seven areas of the national People Promise and the key themes of staff engagement and morale.

1.2 The presentation and report also provides an overview of activity to date in respect of sharing the survey results with staff, their feedback in regard to the emerging themes and the development of resultant action areas.

1.3 The presentation also provides a high-level overview of the staff engagement scores for organisations across the Cheshire & Merseyside system with identification in movement from the previous survey year. Organisations are currently sharing their own results and developing localised action plans in line with staff feedback. Further overview of system results will be discussed at the April meeting of the Board.

2. Introduction / Background

2.1 The national Staff Survey was undertaken during the period September to November 2022 and follows an agreed national format with questions aligned to areas of the People Promise and the themes of staff engagement and morale. As a new organisation, there was no mandated requirement in 2022 to undertake the survey however the ICB felt it was important to undertake the survey to ascertain staff opinion and to establish a baseline of staff views for future benchmarking and comparison. Nationally 37 ICBs also undertook the survey. Our response rate was 65% with 172 staff also providing free text comments. The embargo on the national reporting and publication of the Staff Survey Results was lifted on 9th March 2023.

3. Staff Survey Results and Action Areas

3.1 Staff Survey Results 2022. The ICB results are detailed in the complementary staff survey presentation. At a high level, the ICB staff engagement score is 6.72 and staff morale is 5.73. The ICB score against the 7 areas of the People Promise are detailed below:

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

3.2 Following a review of the results and comparison to other peer group organisations, we scored positively in the following areas:

- Interpersonal relationships within teams including interactions within teams, kindness and understanding shown at team level and handling of local disagreements
- Lower instances than in comparative sectors in relation to Discrimination, Bullying and Harassment and Physical violence.

3.3 Following this review and comparison, the following key areas for improvement and ongoing development were identified:

- Celebration and Recognition – congratulation to individuals and teams, feeling valued at work, respecting individual differences, celebrating success, constructive feedback
- Health & Wellbeing of Staff – creating a positive climate, taking positive action, raising awareness of what is available
- Retention of Staff – having the conversation early, a robust approach to staff feedback
- Learning – effective appraisal system, opportunity to develop career
- Capacity to undertake role – managing time pressures, having enough staff, avoiding duplication and duel running
- Motivation at Work – understanding personal responsibilities, ability to influence and be involved in change at work, looking forward to work and recommendation of the ICB as a place to work.

3.4 172 narrative free text comments were also submitted from staff in support of the structured questions within the survey. We have conducted a thematic review of the feedback with key themes emerging around:

- Organisational Restructure and change leading to concerns in respect of job security
- Connection and engagement with Leaders across the ICB
- Staff Morale impacted by factors both internal to the ICB and within the NHS
- Work Environment in terms of balance of agile working and opportunities for face-to-face interactions.

3.5 **Reviewing the Results and Developing the Action Areas.** Following the initial sharing of our results (under embargo conditions), a meeting of representatives from all teams across the ICB was held on 20th February 2023. This Staff Survey engagement forum met to undertake a collaborative review of the findings, explore any themes, identify areas for action and agree on going dissemination and engagement across the ICB. A dedicated session of We Are One was held on 15th March to share the results widely and engage with staff to help inform areas of improvement and plans for future engagement. This session also utilised an interactive engagement tool to ask for staff feedback across areas including reward and recognition, staff engagement, health & wellbeing, and leadership. A detailed report of this session and feedback was shared as part of the following weekly bulletin.

4. Recommendations

4.1 The Board is asked to note the ICB results and endorse the actions taken to review, disseminate and respond to the Staff Survey results 2022.

5. Next Steps

5.1 Members of the staff survey engagement forum agreed to share and engage with local teams in respect of the results. A follow up meeting will take place on the 29th March to review any local feedback in respect of the findings in addition to the outputs of the We Are One Session, agree a set of organisational actions across priority themes and confirm on-going arrangements for monitoring and reporting. In support of this approach there will also be:

- assurance reporting to the Finance & Investment Committee on 25th April
  Publish the Staff Survey Action Plan in early April 2023
- launch of a new ICB Staff Engagement Group in April 2023 as part of a proposed integrated internal communications and staff engagement framework
- further analysis as more benchmarking information becomes available and areas for ongoing review and deep dive are identified.
- establishment of a new People Committee to provide assurance in respect of the internal people agenda.

6. Officer contact details for more information

Suzanne Burrage,
Head of Staff Experience, Engagement & Wellbeing
Suzanne.burrage@cheshireandmerseyside.nhs.uk

NHS
Cheshire and Merseyside

Integrated Care Board Meeting
30th March 2023

Staff Survey Results & Actions 2022

Agenda (supported by Board Paper)

NHS Cheshire and Merseyside

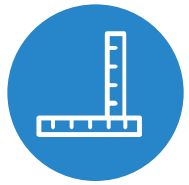
1. Background to Staff Survey & Methodology
2. Cheshire & Merseyside Staff Engagement Scores
3. Cheshire & Merseyside ICB Scores and Key Findings
4. Sharing, Listening and Action

Background To The Survey/Methodology

Background

NHS
Cheshire and Merseyside

National Annual Staff Survey – supported by People Pulse



Used by NHS England, and by CQC, to judge and assess Trust performance

.

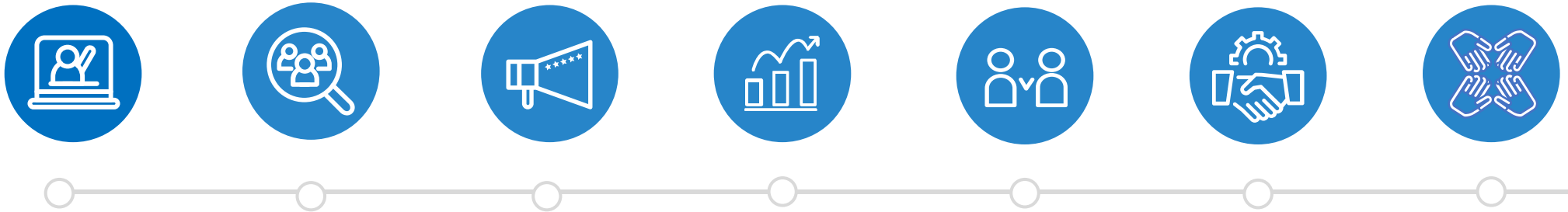
Definite correlations between staff engagement, patient experience and patient outcomes

Survey content – stable since 2021

Content wrapped around People Promise, Staff Engagement and Morale scores

Methodology

NHS
Cheshire and Merseyside



Online Survey

Survey fieldwork undertaken between Sept/Nov 2022

.

Multiple reminders to staff

.

Sample designed to ensure good statistical comparability between organisations and good statistical comparability over time

Comparability within organisations less robust, unless additional samples are used

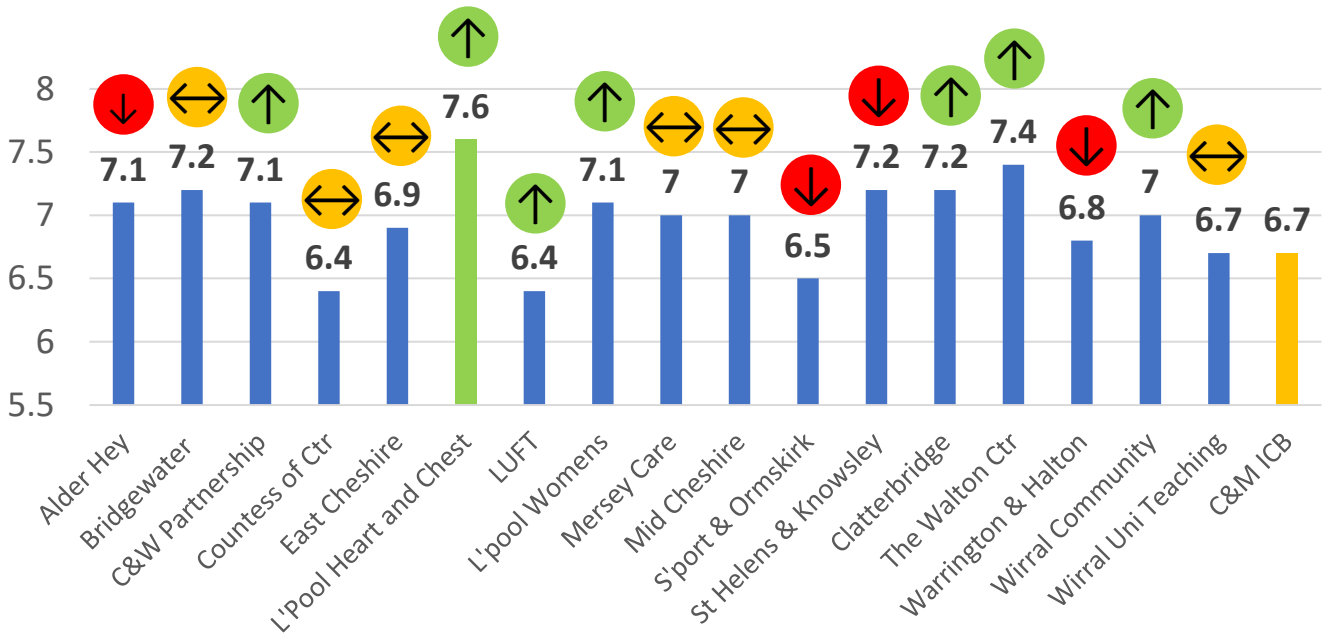
IQVIA worked with 118 organisations overall

Cheshire and Merseyside ICB's 1st Survey, 65% Response Rate compared to average of 44.7% across IQVIA participants

Cheshire & Merseyside Trust Scores

Cheshire and Merseyside

People Promise: Staff Engagement



System View:

Staff Engagement has decreased in 2020 from 7.00 to 6.9 in 2022

There are three sub groups in this theme:

- Advocacy which has fallen over the last three years from 7.3, 6.9 and 6.8
- Involvement fell by .1 in 2021 and recovered by that amount in 2022
- Motivation fell from 7.3 after 2020 to 7.0 where it remained in the 2022 survey results

↑ ↔ ↓ Change since last survey

Cheshire & Merseyside ICB Scores and Key Findings

ICB Staff Survey 2022 – Our Results

NHS Cheshire and Merseyside

Key Measures and Scores

65%	172	6.72	5.73
Response Rate	Comments	Engagement	Morale

Ranked People Promises for your organisation

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

Key Findings

Areas of Positive Feedback:

- Interpersonal relationships within teams
- Lower instances than in comparative sectors in relation to:
  - Discrimination
  - Bullying and Harassment
  - Physical violence

Opportunities for Development:

- Celebration and Recognition
- Health & Wellbeing of Staff
- Retention
- Learning
- Capacity to undertake role
- Motivation at Work (being engaged and involved at work)

Top 5 Themes - Staff Comments:

- Organisational restructure and change
- Job Security
- Leadership
- Working environment
- Morale

Cheshire & Merseyside ICB
Sharing, Listening, Action

‘We Are One’, Staff Survey 2022 Feedback:

You Said, We’re Listening: **Themes**

NHS
Cheshire and Merseyside

Valuing & recognising staff

Flexible & Hybrid Working

Organisational structure

Learning and Development & Opportunities for growth

Staff Retention

Staffing

Clarity of role and teams

Interaction with leaders & colleagues

Knowing who’s who

Transparency

‘We Are One’, Staff Survey 2022 Feedback:

You Said, We’re Listening: **What You Said**

Cheshire and Merseyside

‘feeling valued and even small wins being recognised’

‘Timeframes for when structures will be in place e.g. central ICB teams for patient safety’

‘Retaining good staff, local knowledge...’

‘Clarity on roles and ways of working within new structures’

‘Know who the leaders are and what exactly the ICB is there for’.

‘Flexible working from home and time in the office to discuss face to face’.

‘Development opportunities so staff have a chance to progress’

‘Recruitment to vacant positions’

‘Clearer leadership- more open engagement with team members’.

‘Openness transparency fairness - currently feels missed'

ICB Sharing, Listening, Action

NHS
Cheshire and Merseyside

1

Collaborative meeting C&M ICB Representatives 20th Feb and Follow Up to agree Action Plan

2

Presentation to Executive Team by Survey Provider on 9th March 2023 (embargo lifted)

3

Sharing Results and engaging with all staff at "We Are One' 15th March 2022

4

Sign Off Action Plan, further analysis, align actions, monitor & report on progress

5

Launch ICB Staff Engagement Group to support work programmes and monitoring

ICB Sharing, Listening, Action

NHS
Cheshire and Merseyside

Refresh staff engagement mechanisms & launch ICB Engagement Group

Review, align & promote our health & wellbeing offer across the ICB

Co-design and implement a learning & organisational development plan

Review and launch streamlined Appraisal process

Implement a new induction & welcome programme – corporate and localised

Review our retention approaches and have early conversations

Localised discussions regarding work plans and capacity

Develop a robust and meaningful reward and recognition programme

Implement a new model of governance and involvement for the "people" agenda

NHS
Cheshire and Merseyside

Questions

Cancer Report

Cheshire and Merseyside Cancer Alliance

NHS Cheshire and Merseyside
Board Meeting
30th March 2023

Cheshire and Merseyside Cancer Alliance

NHS

Table of Contents

1. Executive Summary

Cheshire & Merseyside Cancer Alliance brings together organisations, patients and others affected by cancer to drive improvements in clinical outcomes and patients' experience of the care and treatment they receive.

The Alliance is funded by NHS England and is accountable to the national cancer programme for the local delivery of the NHS Long Term Plan ambitions for cancer, and for improving performance against national cancer waiting times standards.

The Alliance leads a comprehensive transformational work programme which aims to improve the early diagnosis of cancer, reduce health inequalities, support the adoption of best practice and innovation, and improve the productivity, effectiveness and efficacy of cancer services.

Demand for cancer services has increased year on year, with referrals up by 30% since the start of the COVID-19 pandemic. This rise in demand has been met with a similar increase in capacity to see new patients in secondary care, largely delivered through better pathways and increased productivity. However, capacity constraints especially in key diagnostics such as endoscopy, continue to present challenges.

Significant progress has been achieved in recent months to reduce the over 62 day cancer backlog. The backlog has reduced by 41% since the start of January.

The proportion of cancer patients being diagnosed with early stage cancer is increasing, especially for lung cancers where performance has been poor historically. The Alliance-led targeted lung health check programme is contributing to this improvement.

Performance against the 31 day and 62 day standards in Cheshire and Merseyside is consistently better than performance across the North West and England. Cheshire and Merseyside's greatest challenge (in addition to continuing to reduce the backlog) is to improve performance against the 28 day faster diagnosis standard. All providers have agreed planning trajectories to meet the operational standard of 75% by March 2024, in line with the national expectation. The Alliance is investing in excess of £7 million in 2023/24 to support improvements in operational performance.

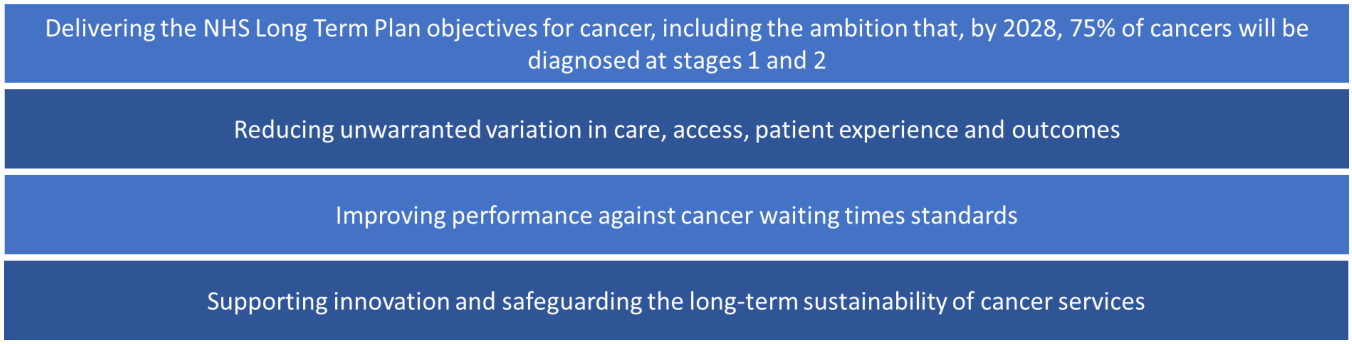
The Alliance works closely with each of the nine places within NHS Cheshire and Merseyside and will continue to include place-based colleagues in discussions around future investments into local initiatives with service providers. The Alliance welcomes the opportunity to work with the ICB to agree longer-term commissioning arrangements for initiatives with proven benefits for patients and service efficiencies. The Alliance is also keen to explore how best to support the ICB with its new commissioning duties for specialised cancer services which are to be delegated to the ICB from NHS England.

2. Introduction

Cheshire and Merseyside Cancer Alliance is an NHS organisation that brings together healthcare providers, commissioners, patients, cancer research institutions and voluntary & charitable sector partners to improve cancer outcomes for our local population, including the Isle of Man[1].

The Alliance is funded by, and accountable to, the national cancer programme within NHS England. The Alliance is hosted by The Clatterbridge Cancer Centre NHS Foundation Trust on behalf of all Alliance partner organisations.

Our key responsibilities include:



Working collaboratively with our partners, the Alliance aims to achieve:

- **Better Cancer Services,** by providing access to expertise and learning; leading change in care pathways, and in piloting new scientific innovations;
- **Better Cancer Care,** by sharing and building on good patient experience and best practice;
- **Better Cancer Outcomes**, by increasing early detection, early diagnosis, enabling early access to cancer services and pathways, and ensuring cancer patients have access to the support they need to live long fulfilling lives beyond cancer.

The Alliance is governed by a Board with a membership representing partner organisations across all geographical areas. Assurance is via the Board up to the national cancer programme in NHS England via the medical directorate of NHS England North West. The Alliance also reports into NHS Cheshire and Merseyside ICB and Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST).

In addition, the Alliance provides programme management office (PMO) support to the Cheshire and Merseyside community diagnostic centres (CDC) programme and the wider C&M diagnostics programme.

The Alliance governance structure is presented in Appendix One.

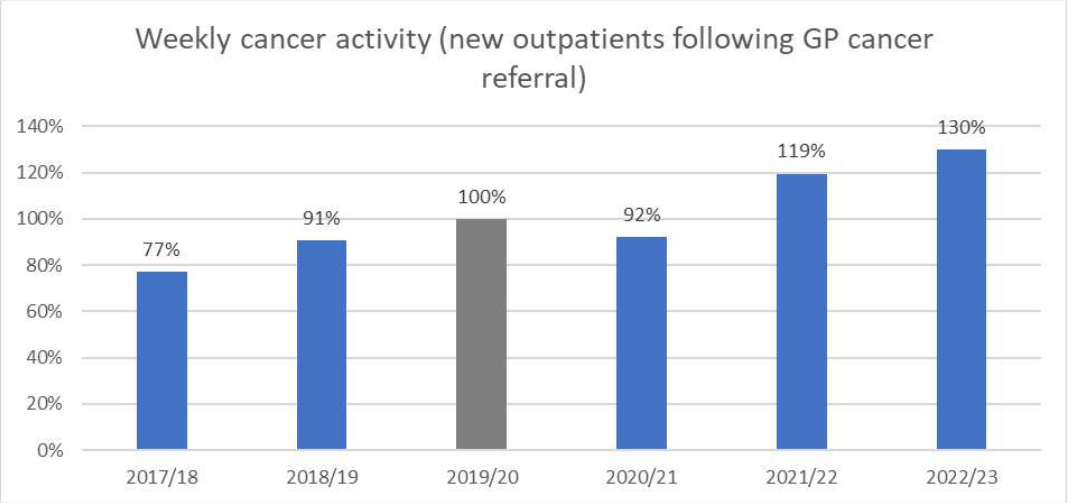
[1] The Isle of Man is a self-funding member of the Cancer Alliance. The island's health services are independent of the NHS but look to Cheshire and Merseyside for specialist cancer services and service improvement advice.

3. Operational Performance

3.1. Urgent suspected cancer referrals and diagnostic demand

GP cancer referrals in Cheshire and Merseyside have been amongst the highest in England and continue to grow in numbers year on year. The high volumes of patients coming forward with symptoms that could indicate cancer have put pressure on both primary care and hospital teams to manage the demand. An additional 3,000 new patients are being seen in cancer clinics every month, compared with three years ago, representing a 30% increase in capacity since the beginning of the COVID-19 pandemic.

On average, it takes between six and 10 diagnostic tests to confirm a cancer diagnosis and prepare the patient for treatment, including imaging tests such as MRI, CT and PET, endoscopic examinations such as colonoscopies and gastroscopies, and pathological tests including biopsies and a growing number of complex genetic tests. Treatments for confirmed cancers include surgery, chemotherapy, radiotherapy and, increasingly, immunotherapies which often require life-long intervention. The growth in urgent suspected cancer referrals, therefore, has a significant impact on demand for many types of hospital services; many of which are highly specialised and require coordination between multiple clinical teams and often multiple hospital trusts. A third of all cancer patients' pathways involve more than one hospital trust just to get to the first treatment, with further referrals required for subsequent treatments such as radiotherapy or chemotherapy.



Demand for cancer services has been steadily rising over many years, excepting a reduction at the start of the pandemic.

2019/20, being the last full year before the pandemic, is highlighted as the baseline.

Source: Cancer Waiting Times

Referrals for patients with suspected lower gastrointestinal (LGI) cancers (including bowel cancers) have increased faster than other tumour types. Sixty percent more patients are being seen in LGI cancer clinics every week compared with 2019/20 – double the average increase across all cancer pathways. This, in turn, has significantly increased the demand for complex diagnostic tests including colonoscopies and CT colon.

Cheshire and Merseyside Cancer Alliance is working closely with the Cheshire and Merseyside Diagnostics Programme to monitor and improve access to all diagnostic modalities. Improving

timely access to endoscopy for LGI cancer patients is a priority. Investments in capacity and productivity aim to achieve a maximum waiting time of seven days for a colonoscopy for suspected cancer patients. The continued roll-out of faecal immunochemical tests (FIT) presents an opportunity to safely avoid the need for a colonoscopy in up to 60% of patients.

Six community diagnostics centres (CDCs) are now operational across Cheshire and Merseyside. Three more sites are due to open shortly. The Cancer Alliance is working with the CDCs to ensure that the additional capacity benefits cancer patients by investigating suspected cancer patients within CDCs and/or by utilising CDC capacity for non-cancer patients to create additional space in the existing hospital services for suspected cancer patients.

The Cancer Alliance is leading a comprehensive improvement programme to embed best practice pathways across Cheshire and Merseyside. The Alliance will have supported all 90+ clinical cancer teams to review, redesign and improve cancer pathways by the end of 2023/24. The Alliance is investing in excess of £7 million to improve cancer diagnostics in 2023/4 through embedding best practice, supporting innovation and investing in the workforce.

3.2. Cancer treatments, routes to diagnosis and conversion rates

Higher numbers of cancer referrals have resulted in increased numbers of patients being diagnosed with confirmed cancers and moving on to treatment. On average, each patient has 1.4 treatments and each treatment may involve multiple appointments over several weeks (e.g. radiotherapy and systemic anti-cancer treatments including chemotherapy) or years (e.g. immunotherapies).

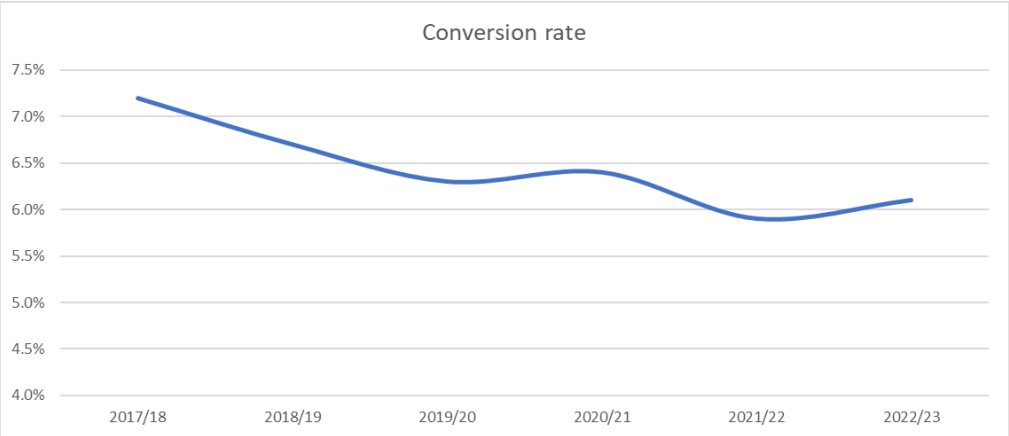
During 2022/23, on average, 94.8% of cancer patients started their first treatment within 31 days of a diagnosis, and 96.3% of patients started their subsequent treatments within 31 days of being clinically ready to receive it.

Whilst many patients are diagnosed following an urgent suspected cancer referral from a GP or dentist (38%), others are diagnosed through the national screening programmes (6%), emergency presentation through A&E (19%) or following a routine GP referral (21%). The relative proportions between these routes to diagnosis were disrupted temporarily during the first few months of the COVID-19 pandemic, but they have settled back to the same as they were pre-pandemic.

Despite the large increase in urgent suspected cancer referrals seen over the last two years, the conversion rate has only dropped marginally, continuing a longer term trend. The conversion rate is the proportion of urgent suspected cancer referrals that go on to be diagnosed as confirmed cancers.

The conversion rate currently stands at 6.15%, i.e. nearly 94% of patients investigated for cancer following an urgent referral will have cancer excluded following tests. Whilst 6.15% may seem low, it is important to note that this may actually be too high. The National Institute for Health and Care Excellent (NICE) use a threshold of 3% when determining which symptoms should be

included in referral guidelines, and it is recognised that many early stage cancers (i.e. the most treatable cancers) may exhibit only mild or vague symptoms. And of course, many patients that are found not to have cancer may still have very serious conditions that require treatment.



Although referral rates have increased by 30% since 2019/20, the conversion rate has only reduced slightly from 6.3% to 6.15%.

Source: National Cancer Registration and Analysis Service and Cancer Waiting Times

3.3. Cancer waiting times standards

National cancer waiting times standards include three key indicators:

- The proportion patients who receive a diagnosis of cancer, or who are told that they do not have cancer, within 28 days of an urgent suspected cancer referral;
- The proportion of patients who begin their first cancer treatment within 31 days of a decision to treat;
- The proportion of patients who begin their first cancer treatment within 62 days of an urgent suspected cancer referral.

Cheshire and Merseyside performs better than the England average and the North West average for both the 31 day and 62 day cancer standards. However, the 31 day standard is not consistently achieved, and the 62 day standard has not been achieved for a considerable time.

The 28 day faster diagnosis standard is a significant challenge, with performance in Cheshire and Merseyside below the regional and national averages. Improving performance against the 28 day standard is a key priority for 2023/24. All providers have confirmed planning trajectories (including mid-year milestones) to be fully compliant by March 2024 in line with the national expectation.

	28 Day Faster Diagnosis Standard	31 Day First Treatment Standard	62 Day Urgent Referral to First Treatment Standard
Operational standard:	*75%*	*96%*	*85%*
Cheshire and Merseyside	65.50%	95.80%	67.30%
Greater Manchester	64.90%	94.40%	62.00%
Lancashire and South Cumbria	69.30%	89.20%	60.00%
North West Region	66.20%	93.50%	63.50%
England	70.70%	92.70%	61.80%

Source: Cancer Wiatitng Times, December 2022

Over recent months, Cheshire and Merseyside has performed better than the North West and England against the 31 and 62 day targets, but 28 day FDS performance is lower.

3.4. Cancer backlog

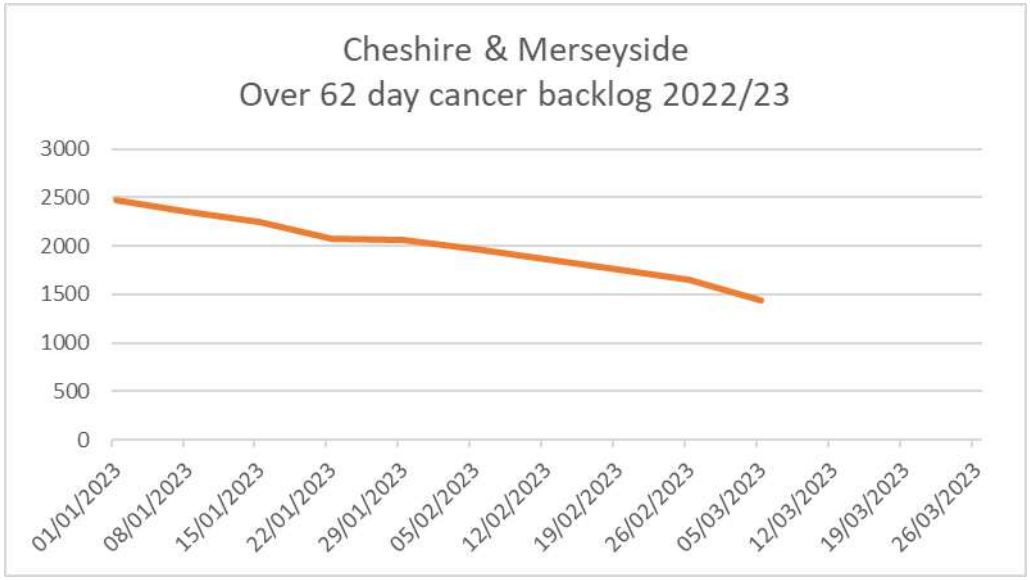
Despite increased capacity and productivity, demand for cancer services (especially diagnostics) has outstripped supply at several points in time during the last three years. Even though more patients than ever are being seen, diagnosed and treated within the timescales set by the national cancer waiting times standards, there are significant numbers of patients who wait longer.

Of particular concern are the patients who are still being investigated for suspected cancer and/or waiting for treatments more than 62 days following an urgent referral. This is known as the cancer backlog.

There are currently 14,137 patients being investigated for possible cancer at hospital trusts in Cheshire and Merseyside. Sixty percent of patients have been referred in the last month. Ninety percent are still within 62 days of their referral, but 10%, 1,444 patients, are still being investigated beyond 62 days. This is higher than the national average of 7.8%.

Cancer diagnostic pathways are complex and, on average, involve six to 10 diagnostic investigations and multiple clinic appointments. It is expected that some patients will take more than 62 days to diagnose and, if cancer is found, prepare for treatment, due to clinical complexity. For this reason, the 62 day referral to first treatment standard is set at 85%. However, we are aware that there are significant numbers of patients still being investigated after 62 days who have experienced delays due to lack of hospital capacity, which is unacceptable and must be addressed.

The cancer backlog in Cheshire and Merseyside has reduced by 41% since 1st January 2023. Whilst this is an important improvement, the aim is to reduce this further from 1,444 to 1,075, which is considered to be the appropriate number to take into account clinical complexity. Each provider has agreed a trajectory to achieve this target level by March 2024. However, the Alliance is keen to reach and then maintain this target significantly earlier.



The number of patients still being investigated for suspected cancer more than 62 days after an urgent cancer referral has reduced by 41% since the beginning of the year.

Source: National Cancer Patient Tracking List (PTL)

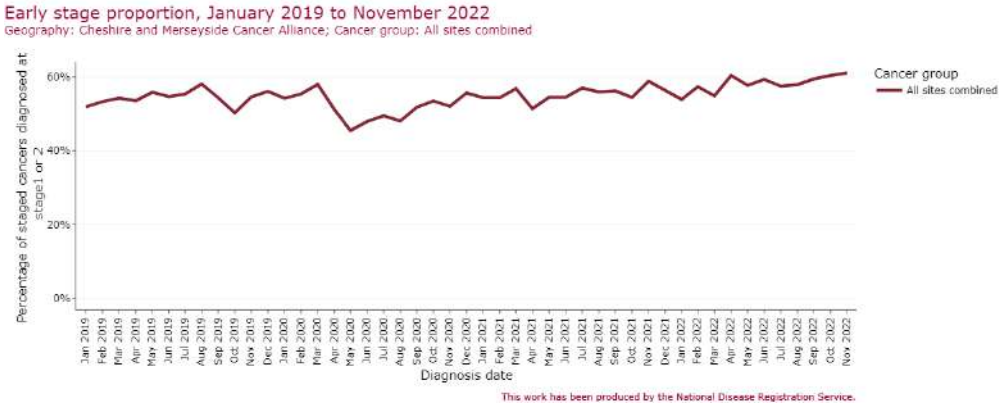
3.5. Early cancer diagnosis

The cornerstone of the national strategy for cancer, as detailed in the NHS Long Term Plan, is to increase the proportion of cancers that at diagnosed at an early stage, when treatment is more effective and survival outcomes are maximised. Specifically, the NHS aims for 75% of new cancers diagnosed to be early stage (stages 1 and 2) by 2028.

The NHS both locally and nationally has a long way to go to meet this target. It was feared that the impact of the COVID-29 pandemic would result in more cancer patients presenting later and therefore being diagnosed with late stage disease (stages 3 and 4).

However, the most recent data show that the proportion of cancer diagnosed at an early stage has increased. These data show improvements both nationally and for Cheshire and Merseyside. All the four most common cancers have either shown improvements or maintained their position. Lung cancer has shown the most positive improvement, which may be due to the impact of the targeted lung health check programme. Bowel cancers – where the biggest service challenges and delays to diagnosis have been seen – have neither seen an improvement nor a deterioration.

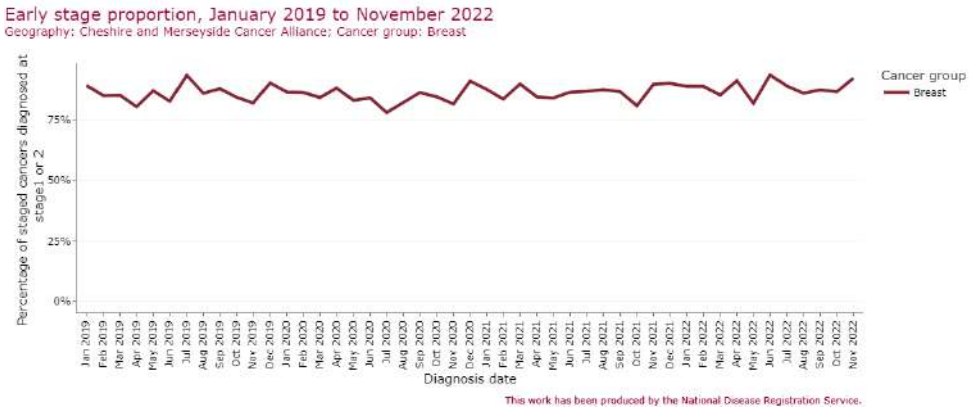
In 2023/24 the Cancer Alliance will be investing approximately £2 million to improve the early diagnosis of cancer through initiatives including generic screening for people at risk of colorectal and endometrial cancers (Lynch Syndrome) and screening individuals at high risk of developing liver and pancreatic cancer. Additionally, the successful targeted lung health check programme will be expanded with an investment yet to be confirmed, but likely to be in excess of £7 million.



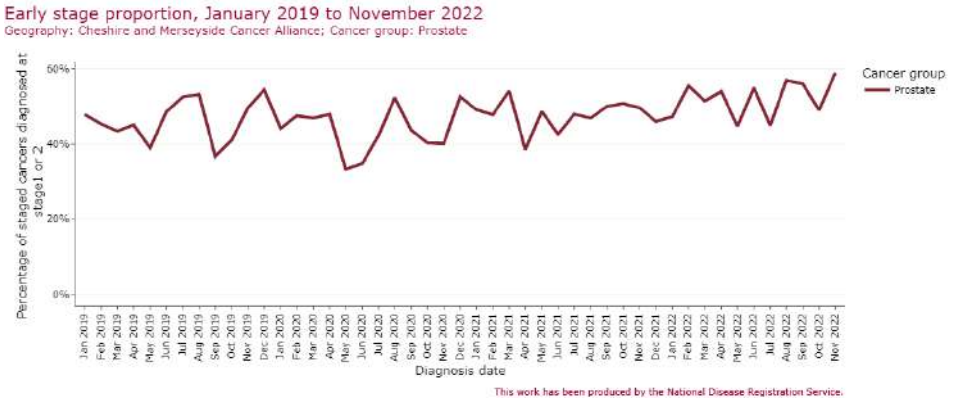
The proportion of all cancers diagnosed at an early stage has increased despite the impact of the pandemic.

This is similar to the national trend.

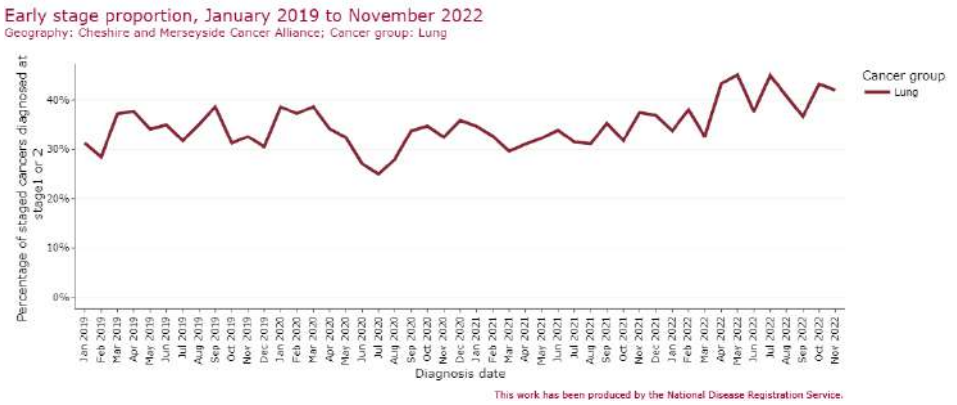
Source: National Cancer Registration and Analysis Service



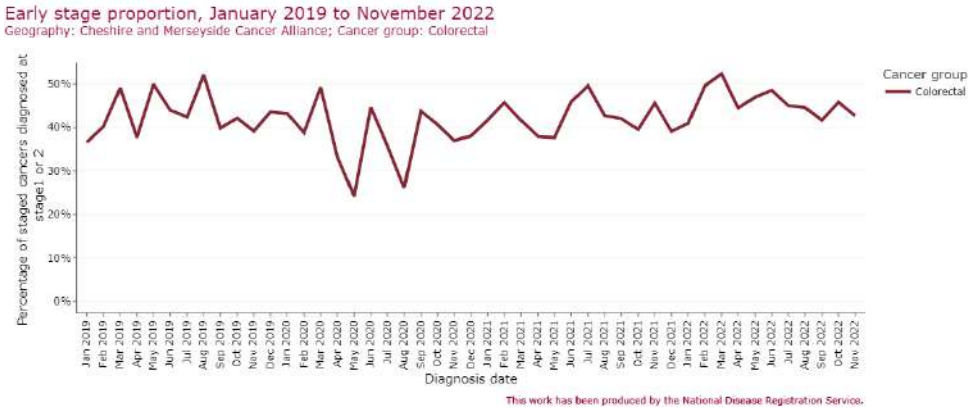
Breast cancer early diagnosis rates have remained relatively static.



Prostate cancer early diagnosis is starting to improve marginally,



Lung cancer early diagnosis has seen the biggest improvement. This may be due to the Alliance's targeted lung health check programme which commenced in July 2021.



Colorectal cancer early diagnosis has remained relatively static despite delays to the pathway due to high volumes of referrals.

4. Work Programme 2023/24

Each year the Cancer Alliance oversees a comprehensive portfolio of programmes designed to reduce cancer inequalities, improve operational performance and deliver the NHS Long Term Plan milestones for improving the early diagnosis of cancer. The NHS operational planning guidance sets out the objectives for cancer annually, and the Alliance responds by constructing a detailed plan which is signed-off by the Cancer Alliance's Board, the ICB, NHS England North West Region and ultimately the national cancer programme within NHS England. The Alliance's work programme is funded directly from the national cancer programme.

The national objectives for Cancer Alliances for 2023/24 are set out in Appendix 2, along with a summary of each of the main programmes with within the Alliance's portfolio.

2023/24 will build upon the success of existing programmes such as the Alliance's education hub - the Cancer Academy – and early diagnosis initiatives such as the targeted lung health check programme and the NHS Galleri clinical trial.

Examples of the Alliance's achievements over the last 12 months are listed below.

Key achievements in 2022/23 (examples only)

Activity	3,000 additional new patients seen each month. Equivalent to seeing an extra week's worth of work every month.
PSFU	41 personalised stratified follow-up (PSFU) protocols now live. 100,000+ outpatient appointments saved.
FIT	£2m Alliance investment. 83,000 kits issued. Colonoscopy avoided in 60% of patients following FIT.
Prehabilitation	5% reduction in LoS. Up to 50% reduction in complications. 8% reduction in 30 day readmissions. >90% patients report psychosocial benefit.
Faster Diagnosis	21 best practice timed pathways fully established – top performing Alliance in England. Improved / redesigned pathways supported by approx. 60+ clinical, non-clinical and scientific roles funded by the Alliance.
Education	Over 500 learners registered on CMCA's Cancer Academy since its launch four months ago. 15 new endoscopists trained through accelerated endoscopy qualification programme.
Patient experience	10 community outreach roadshows into most deprived areas. 25 patient representatives and 15 story tellers recruited. 25-member readers panel established.
Health Inequalities	Over 30 small grants awarded to voluntary and community groups to lead local cancer awareness initiatives.
Targeted Lung Health Checks	80,000 invited since starting in July 2021. 73% cancers found are stage 1 or 2. Fastest roll-out in England.
NHS Galleri	World's largest clinical trial. CMCA is highest recruiter. Over 22,000 participants across all C&M places.
Innovation	Europac Plus – Risk stratified screening for patients at risk of pancreatic cancer. C&M is national exemplar.

4.1. Sustaining improvements through commissioning decisions

The Cancer Alliance is keen to work ever more closely with the ICB to ensure that improvements to cancer performance and patient outcomes delivered through the Alliance's transformational work programme can be sustained long term.

In 2022/23 the Alliance developed 'place packs' for each of the nine places within NHS Cheshire and Merseyside. These summarised the Alliance-led activities and investments in each geography to help facilitate ongoing collaborative place-based conversations and inform commissioning intentions. The Alliance will continue to produce these place packs annually, as well as involving place-based colleagues in discussions with providers around future initiatives and investments from the Alliance.

Several Alliance-led initiatives impact on all places within the ICB, and for these the Alliance would anticipate benefit in engaging in a single ICB-wide discussion about future commissioning arrangements as well as progressing place-based conversations. Current examples include funding discussions around faecal immunochemical testing (FIT), non-specific symptom pathways (NSS) and strategic alignment discussions around pre-habilitation services and teledermatology.

The Alliance is also keen to explore how it may support the ICB with the strategic commissioning of specialised cancer services being delegated to ICBs from NHS England.

5. Recommendations and Next Steps

The Board of NHS Cheshire and Merseyside is asked to note the contents of this report and support the continued efforts of all system partners, coordinated by the Cancer Alliance, to further improve operational performance and outcomes for cancer patients.

The Alliance looks forward to ongoing constructive conversations regarding how improvements led by the Alliance can be maintained and embedded by the ICB into longer term commissioned services, including FIT, NSS, prebilitation and teledermatology services.

The Alliance is keen to explore how it may support the ICB with its new commissioning duties for specialised cancer services which are to be delegated to the ICB from NHS England.

Appendix 1: Governance Structure

Internal Governance

Alliance Board
(Quarterly)

Alliance Steering Group
(Monthly)

Senior Management Team
(Weekly)

Programme Forum
Prevention, early diagnosis, personalised care
(Monthly)

Programme Forum
Workforce, health inequalities & patient experience
(Monthly)

Programme Forum
Faster diagnosis & FIT
(Monthly)

Project Delivery Groups

External Governance

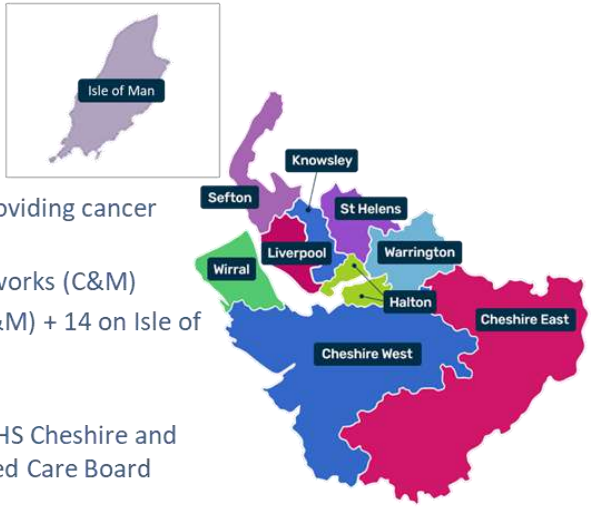
NHSE
National Cancer Programme

NHSE North West (Medical Directorate)

NHS Cheshire and Merseyside (ICB)

Alliance Board

CMAST (provider collaborative)



- Ten ‘places’
- 15 hospital trusts providing cancer services
- 55 primary care networks (C&M)
- 375 GP practices (C&M) + 14 on Isle of Man
- 2.7 million residents
- Coterminous with NHS Cheshire and Merseyside Integrated Care Board (plus Manx Care)

Appendix 2: Plans on a Page 2023/24

Contents

National Objectives for Cancer Alliances

Cheshire & Merseyside Cancer Alliance

Workstream	Programme	Objectives
Faster Diagnosis and Operational Performance	Operational Performance	• Work with systems and providers to develop and implement actions plans to improve Cancer Waiting Times performance with a focus on achieving the Faster Diagnosis Standard (FDS) and reducing the number of the longest waiting patients on cancer pathways waiting more than 62 days.
	Faster Diagnosis NSS	• Deliver 100% population coverage for Non-Specific Symptom (NSS) pathways. • Ensure sustainable commissioning arrangements for NSS pathways are in place for 2024/25.
	Faster Diagnosis BPTP	• Deliver Best Practice Timed Pathway (BPTP) milestones in suspected prostate, lower GI, skin and breast cancer pathways. • Provide universal support to providers performing below the England average to embed BPTP pathway milestones. • Provide intensive support to tier 1 & 2 providers to support improvement of performance against priority cancer pathways.
Early Diagnosis	Timely Presentation	• Set out Timely Presentation objectives, with a particular focus on the most deprived 20% • Establish metrics to measure achievement of objectives and review tracking regularly
	Primary Care Pathways	• Cancer Alliances should outline a clear set of actions and milestones to support PCN DES delivery. • Cancer Alliances should use their contacts and links across secondary and primary care to support Regional Diagnostic Leads implement GPDA guidance
	Targeted Lung Health Checks	• Deliver invitation, Lung Health Check attendance and CT scan run rates in line with expansion plans agreed with the National team. • Deliver uptake of LHCs above 50%. • Develop a clear plan for further expansion in 2024/5.
	Lynch Syndrome	• All colorectal and endometrial cancers should be tested for Lynch syndrome.
	FIT	• To ensure 80% of LGI urgent referrals are accompanied by a FIT result. • To ensure <20% of colonoscopies performed on the LGI FDS pathway do not have an accompanying FIT result. • To ensure fewer than 40% of colonoscopies are performed on patients with a negative FIT result (excluding patients with no FIT result).
	Liver Surveillance	• Liver Services to invite >80% of patients with cirrhosis to 6-monthly ultrasound surveillance, support >60% of those invited to attend. • To pilot blood tests/fibroscans for those at high risk of fibrosis/cirrhosis, identified through a search of primary care data, and refer for liver surveillance.
	Cytosponge	• Maintain delivery of Cytosponge in secondary care, support the evaluation, and agree an onward strategy for transition into BAU commissioning.
	Local Innovation	• Identify, fund, support and share learnings from local innovations that enable delivery of LTP commitments with a particular focus on early diagnosis.
Treatment and Care	GRAIL	• Support retention & onward referral of patients in the NHS-Galleri Clinical trial
	Treatment Variation	• GIRFT implementation: Alliances to continue to oversee the implementation of 3 selected treatment recommendations from the national lung GIRFT report. • National Cancer Audit Implementation: Alliances to oversee the implementation of one priority recommendation from each of the 4 existing clinical audits for cancers other than lung cancer.

	Living with and beyond Cancer	• Ensure the following personalised care interventions are available for all cancer patients, and data is submitted to COSD for:
		  • Personalised Care and Support Planning (PCSP) based on Holistic Needs Assessment (HNA).
		  • End of Treatment Summary (EOTS).
		• Ensure fully operational and sustainable PSFU pathways for all suitable patients in breast, prostate, colorectal and endometrial cancer.
		• Ensure delivery of the Cancer Alliances' psychosocial support development plan.

Cross-Cutting	Experience of Care and Patient Engagement and Involvement	• Cancer Alliances are asked to work with systems and trusts to ensure they use insight and feedback to develop and deliver coproduced (with people with relevant lived experience and staff) quality improvement action plans to improve experience of care that are at the core of priority work programmes • Cancer Alliances to establish and maintain a people and community engagement structure to enable Coproduction throughout work programmes and in conjunction with local ICB's and Trusts.
	Workforce	• Cancer Alliances to understand cancer workforce priorities in their area and work with regional workforce and education & training leadership to address priority areas of need.

2023/24 Faster Diagnosis Overview

Cheshire & Merseyside Cancer Alliance NHS

1. Programme Key Roles

SMT Lead	Greg O'Mara
Senior Programme Managers	Anna Murray / Gemma Hockenhull

2. Programme Aim

The programme represents a continuation of the multi-year Faster Diagnosis (FD) programme and incorporates key objectives from the Faster Diagnosis Framework (published 2022) and the 2023/24 Operational Planning Guidance.

The aim of the programme is to:

- Support earlier and faster diagnosis through the development of efficient diagnostic pathways
- Deliver standardisation across services where clinically appropriate and share best practice (e.g. Best Practice Timed Pathways), with a focus on evaluation and sustainability of all fast diagnosis developments
- Work with individual trusts to achieve the 75% Faster Diagnosis Standard (FDS) by March 2024

3. Background and Strategic Context

The 2023/24 operational planning guidance sets out expectations that achieving the Faster Diagnosis Standard (FDS) by March 2024 is critical to maintaining confidence in cancer services. This is essential in order to meet the growth in demand, which is a pre-requisite to improving Early Diagnosis. CMCA will continue to work with providers to implement optimal pathways, published Best Practice Timed Pathways (BPTP) and priority pathway improvements whilst adhering to the FD key principles outlined below.

Faster Diagnosis Key Principles

Early Identification	Timely Referral	Broad Assessment of Symptoms	Coordinated Testing	Timely Diagnosis	Appropriate Onward Referral

4. Programme Outcomes & Deliverables

- Deliver 100% population coverage for Non-Specific Symptom (NSS) Pathways by March 2024.
- Ensure sustainable commissioning arrangements for NSS pathways in 2024/25. Support providers to draft and submit local business cases
- Support providers to develop new routes into NSS pathways, such as re-direct pathways from emergency care and other urgent suspected cancer pathways.
- Deliver Best Practice Timed Pathway (BPTP) milestones in prostate, lower GI, skin and breast cancer pathways
- Assess local priorities and draw on BPTP documents for other areas to agree improvement plans
- Work with systems and providers to achieve the 75% Faster Diagnosis Standard (FDS).
- Provide support to providers performing below the England average to embed BPTP pathway milestones.
- (Tier 1 and 2 Only) - Assist the National Cancer Programme in providing intensive support to Tier 1 and 2 providers with the greatest performance issues, working with providers to identify challenges and facilitate pathway improvements.
- Support the implementation of Teledermatology across all Places to support the skin cancer pathway to speed up diagnosis, manage referrals and reduce face-to-face appointments.

5. Key Delivery Risks & Issues

Summary	Score	Mitigation
The scope and scale of the programme is likely to lead to significant sustainability challenges.	9	Develop and deliver evaluation plans to support the on-going sustainability of investments. Where appropriate, sustainability will be raised at a system level with the C&M ICB (e.g. NSS Pathways).
There are risks to achievement of BPTP diagnostic milestones, specifically with regards to MRI and biopsy capacity within Trusts. This also includes capacity to report in a timely manner.	9	Continue to work with Trusts to explore opportunities and internal agreement to ensure available capacity to meet demand. Implementation of new FD models and additional targeted investment in 2023/24 within Trusts is expected to support achievement.

6. Programme Delivery – Projects & Activity to support delivery

Projects	Purpose
Non-Specific Symptom Pathways (NSS)	Complete the implementation of NSS services in three additional trusts (LUHFT – Aintree, WUTH and ECHT) and support the continued expansion of referrals from MUO, A&E, Ambulatory Care and tumour-specific pathways.
Priority Best Practice Timed Pathways (BPTP)	Agree provider plans and allocations of place-based funding targeting the four national priority pathways (prostate, lower GI, skin and breast) and local priority pathways (e.g. upper GI and gynae). Bring together system partners to ensure commissioning of sufficient diagnostic capacity to embed BPTP milestones and improve FDS performance.
Bladder and Kidney Optimal Pathway	Implementation of C&M Optimal Pathway across all Trusts delivering diagnostic services for bladder and kidney cancer as part of the urology service, incorporating BPTP events and timings as well as FD Core principles.
Liver and Pancreas Optimal Pathway	To implement an optimal timed Liver pathway and work with the specialist centre to review current Pancreas pathways and commence the development of an optimal timed pathway. This will support the delivery of 28, 31 and 62 day standards.
Head and Neck Optimal Pathway	To implement an optimal pathway for patients presenting with suspected Head & Neck cancers across all sites delivering diagnostic and treatment services across C&M, incorporating BPTP events and timings as well as FD Core principles.
Teledermatology	Support the implementation of Teledermatology across all Places to support the skin cancer pathway to speed up diagnosis, manage referrals and reduce face-to-face appointments.
Breast Pain Clinics	Implement regional community breast pain clinics within C&M for patients experiencing breast pain symptoms to reduce the demand on breast TWW referrals into secondary care.
Children's Cancer Pathway Review	Work with the specialist centre to explore ways to improve referral and diagnosis pathways across the alliance footprint.
Brain ED Pathway	To commence roll-out of the Brain ED Pathway across Cheshire & Merseyside and work with the specialist centre to design the optimal Brain/CNS Pathway for patients presenting in primary care.

2023/24 FIT Programme Overview

Cheshire & Merseyside Cancer Alliance NHS

1. Programme Key Roles

SMT Lead	Greg O'Mara
Senior Programme Manager	Anna Murray

2. Programme Aim

The aim of the FIT programme is to build on progress made from 2018 to 2022, ensuring that a consistent FIT model is in place across Cheshire & Merseyside, supported by an effective pathology model and that all patients with Lower GI symptoms receive a FIT where clinically appropriate and in line with guidance and emerging evidence. Furthermore, the programme aims to ensure that there is appropriate evaluation and closure of the backlog/surveillance FIT project that has supported endoscopy recovery.

3. Background and Strategic Context

Comprehensive use of FIT in NG12 patients is critical to making the best use of our available colonoscopy capacity, ensuring patients on the lower GI pathway can be diagnosed promptly and improving bowel cancer diagnosis and survival in England in the long term. The NHS Planning Guidance 2023/24 requires that systems should implement and maintain priority pathway changes for lower GI (at least 80% of FDS lower GI referrals are accompanied by a FIT result). Five national deliverables have been identified for Cancer Alliances to work with their systems to deliver. Additional deliverables have also been identified at CMCA-level (see below).

4. Programme Outcomes & Deliverables

National deliverables:

- Established pathway in place in primary care to limit referrals in those with FIT <10ug and no other concerning symptoms, in line with BSG/ACPGBI guidance
- Established protocol in secondary care for patients referred on the Lower GI FDS pathway with FIT <10ug, FBC and normal examination, either to be discharged back to their GP or rerouted onto an alternative pathway
- 80% of LGI urgent referrals accompanied by a FIT result
- <20% of colonoscopies performed on the LGI FDS pathway do not have an accompanying FIT result
- Minimise the number of colonoscopies performed on patients with FIT<10ug

Success measures:

- CAN-01: Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result.
- Percentage of LGI FDS referrals that at clinical triage fall into the following FIT bandings: <10 ug/gm; 10 – 100 ug/gm; >100ug/gm; No FIT available; FIT not appropriate
- Percentage of colonoscopies performed on the LGI FDS pathway relative to FIT bandings: <10 ug/gm; 10 – 100 ug/gm; >100ug/gm; No FIT available; FIT not appropriate

Additional CMCA deliverables:

- Implementation of the new C&M FIT Pathway and all associated guidance, Primary Care and patient materials across all organisations in the Alliance footprint.
- Exploration and planning for wider comms, education and engagement with Primary Care through GP trainees and GP Locums.
- Delivery of CMCA Comms Plus to support reductions in health inequalities.
- To ensure appropriate phased evaluation and closure of the backlog/surveillance FIT project by financial year end.

5. Progress so far

- Pathology: There are currently four FIT analysers in place across Cheshire & Merseyside with a capacity of 1 million FITs per year. Also agreed: Standardised FIT results comments, ICE requests, unexplained Iron Deficiency Anaemia Guidance for Primary Care
- The Early Diagnosis Support Worker workforce has been enhanced as part of the programme, with clear roles as part of safety netting, patient tracking and Primary Care communication.
- Documentation developed and being implemented across all sites: New C&M FIT Pathway (Five Trust due to go live April 2023; three due to go live May 2023), C&M LGI Prioritisation Guidance, Secondary Care Negative FIT Pathway (Three sites live as of March 2023), TWW referral form, Primary Care Implementation Support Package, patient materials (these will also be produced in easy read, braille and the five main C&M alternative languages), safety netting protocol.
- Comprehensive clinical and operational support for the new pathway from Local Medical Councils, Place, Primary Care Leaders, Regional Team, National FIT Team, ICS, Diagnostic Networks, Clinical Quality Groups.
- C&M FIT MDS in place and new KPIs developed to incorporate national KPIs and enable effective monitoring.
- Approximately 6,000 FITs carried out per month; over 80,000 since FIT went live in 2020.
- University College London paper in British Journal of General Practice shows that FIT is acceptable to patients following commissioned study by CMCA for St Helens & Knowsley Teaching Hospitals NHS Foundation Trust.
- FIT Clinical Leadership established at CMCA-level and for all Place/Trusts either for Primary and/or Secondary Care to support new FIT Pathway implementation.
- CMCA's Comms Plus project will support reductions in health inequalities and further communication with Primary and Secondary colleagues as well as patients. Inclusion of key questions for transgender patients already included within ICE.

6. Key Delivery Risks & Issues

Summary	Score	Mitigation
Sustainability remains a risk for Primary Care FIT.	15	FIT funding provided to Trusts to support FIT testing during 2022/23; additional funding provided by Warrington and Wirral Places to support their respective areas. ICS funding of £500k received in 2022/23 to support FIT; with the ICS including FIT within their plans for 2023/24. This risk has decreased from 16.
There is a risk that pathology will see a greater demand for histopathology in light of FIT use. This may cause additional pressures to the service.	9	Numbers will be monitored via automated FIT KPIs and will be escalated as required. There is currently enough analyser capacity for 1 million FIT tests per year and challenges to the pathology workforce are being mitigated for by pilots in GP Practice FIT Kit Distribution direct to the patient. Outcomes from these local pilots are expected during 2023/24 to inform plans for wider roll-out.

7. Programme Delivery – Projects & Activity to support delivery

Projects	Purpose
Primary Care FIT	Implement the new C&M FIT Pathway and all associated guidance across the Alliance footprint, ensuring evaluation and monitoring is in place. Further aims are to explore opportunities to reduce health inequalities in FIT uptake through evaluation of FIT KPIs. Additionally to ensure ICS FIT sustainability is achieved by Q4 2022/23.
Backlog/ Surveillance FIT	Support endoscopy recovery through FIT completion for eligible patients who are currently on the symptomatic backlog or overdue surveillance. Project is at evaluation and closure phase. All activity has ceased as of 15th October 2022 and all Trusts have reverted back to National Surveillance Guidance.
Pathology	Complete the current Pathology Review and ensure systematic implementation of recommendations, including pilots where appropriate. This includes supporting new C&M FIT Pathway guidance implementation through harmonisation of ICE, supporting GP Practice Distribution Pilots, Unexplained IDA Guidance development support, implementation of new C&M patient instruction leaflet, Network procurement of FIT, safety netting and standardised FIT results reporting across C&M.

23/24 Gynae Programme Overview

Cheshire & Merseyside Cancer Alliance

NHS

1. Programme Key Roles

SMT Lead	Dave McKinlay
Programme Manager	Jen Burgess (from May 23)

2. Programme Aim

The aim of the Gynaecology Programme is to take forward the recommendations of the 2022 Gynaecology Services Review and implement a stakeholder agreed model of care for gynae-oncology services. This will be achieved by working towards a vision and mission for gynaecological cancer services:

Vision

For all gynaecological cancer services in C&M to work as a partnership and collectively be recognised for excellence in patient care, teaching, education and research.

Mission

To provide patient centred, personalised, timely responsive, high quality, evidence-based care for patients with proven or suspected gynaecological cancer.

3. Background and Strategic Context

To support delivery of the NHS Long-Term Plan, including delivery of Faster Diagnosis Pathways by 2024, Cheshire & Merseyside Cancer Alliance (CMCA) commissioned a review of gynaecological services across the Alliance footprint in October 2021.

The review used a mixed methods approach to review data, guidance, service configuration, workforce, current practice, and transformational opportunities for cervical, ovarian, vulval and endometrial cancers both suspected and diagnosed. The review explored services from patient presentation in primary care through to diagnosis and first definitive treatment. The outcome of the review was used to inform the collaborative development of a vision which supports standardised and consistent service delivery and best clinical practice across all sites. The vision would be underpinned by a comprehensive improvement plan with short, medium, and long-term goals that would be owned collaboratively by organisations and delivered over multiple years.

This review is complete and proposed establishment of a model of care for gynaecological cancer services in Cheshire and Merseyside (C&M) and 40 recommendations delivered through a proposed programme. The Gynae programme was established in 2022 to deliver these recommendations.

4. Programme Outcomes & Deliverables

The programme will focus on the following priorities during 23/24:

Priority 1: **Improving time to diagnosis and treatment decision making including one stop clinic.**
Priority 2: Development of a C&M approach to follow up including the use of digitally supported follow up tools
Priority 3: **Establishment of 2 additional cancer units Ensuring that diagnostics and lower complexity treatment happen locally at all cancer units**
Priority 4: **Supporting improvements in cervical screening rates Facilitating and driving development of a system plan for cervical screening with partner organisations**
Priority 5: **Workforce Completing a review of future workforce requirement and gap analysis**

5. Key Delivery Risks & Issues

Summary	Score	Mitigation
The scope and scale of the programme and trust capacity is likely to lead to delivery challenges	6	Consistent programme team supported by a strong board to support delivery. Escalation of challenges and barriers. Programme will deliver focussed priorities initially.
The scope and scale of the programme is likely to lead to significant sustainability challenges	8	Funding provided to organisations will included planning around sustainability. Support the development of economic cases to support sustainability.
There is a risk that agreed optimal pathway timings for diagnostic services cannot be met due to current service demand and workforce challenges	8	CMCA will work with Trusts to complete demand and capacity modelling prior to implementation using a phased approach to manage demand. Transformation work will support better use of existing resources.

6. Programme Delivery – Projects & activity to support delivery

Project	Purpose
Priority 1: **Improving time to diagnosis and treatment decision making including one stop clinic.**	• Expanding access to diagnostic capacity • Implementing one stop approaches in at least 3 additional sites • Reviewing and optimising the approach to MDT including a new system operational policy • Enabling access to CDC capacity • Developing a training centre of excellence for ultrasound • Implementing the C&M Optimal Pathway, National BPTP and FD Core Principles • Piloting a new approach to unscheduled bleeding on HRT
Priority 2: Development of a C&M approach to follow up including the use of digitally supported follow up tools	• Expanding the previous work for endometrial 1a patients to other groups • Establishing a standard follow up protocol across C&M for all groups • Designing and implementing a system model for follow up underpinned by IT and care close to home where appropriate
Priority 3: **Establishment of 2 additional cancer units Ensuring that diagnostics and lower complexity treatment happen locally at all cancer units**	2 sites confirmed as: • Southport & Ormskirk • Warrington & Halton Ensuring that diagnostics and lower complexity treatment happen locally at all cancer units
Priority 4: **Supporting improvements in cervical screening rates Facilitating and driving development of a system plan for cervical screening with partner organisations**	Facilitating and driving development of a system plan for cervical screening with partner organisations
Priority 5: **Workforce Completing a review of future workforce requirement and gap analysis**	• Completing a review of future workforce requirement and gap analysis • Undertaking detailed workforce capacity and capability/ training mapping at several sites • Supporting recruitment to fill gaps or reduce single points of failure • Developing and implementing a CNS policy for system working

2023/24 Personalised Care in Community and Prehabilitation Overview

Cheshire & Merseyside Cancer Alliance NHS

1. Programme Key Roles

Clinical Lead	TBD
SMT Lead	Tracey Wright
Senior Prog Manager	Sarah Houghton
Senior Project Managers	Jen Kelly / Sue Renwick

2. Programme Aim

This programme sets out the Cheshire and Merseyside Cancer Alliance plan to improve patient experience and cancer outcomes in Cheshire and Merseyside through personalised care.
Provide individualised care and support to cancer patients.
Reduce risks and improve long term outcomes and quality of life amongst those diagnosed with cancer
Ensure a positive experience of care and support.
The aim contributes to the overall Long-Term Plan personalised care ambition that:
Where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support
Personalised stratified follow-up pathways are in place for people at the end of treatment so clear and appropriate follow-up plans are in place.
The impact of cancer will be tracked through the Quality of Life metric.

3. Background and Strategic Context

The NHS Long Term Plan outlines two key ambitions, this programme will support delivery of 55,000 more people each year that will survive their cancer for five years or more.
Personalised care has been identified as a key priority within the NHS Long Term Plan.
The plan sets targets for Personalised care to provide people with choice and control over the way their care is planned and delivered. This will empower people to manage their care and ensure they will have access to the right help and expertise to allow them to achieve better short and long term health benefits.

4. Programme Outcomes and Deliverables

Prehab:
- Support the development of a local prehab strategy
- Support the local system to operationalise and evaluate a comprehensive prehab delivery model.
- Development of a defined expressions of interest process with invites extended to Secondary/Tertiary Care Trusts.

Personalised Care Lead Cancer Nurse:
- Explore and define a Community/Primary Care Lead Cancer Nurse role for cancer and/or end of life patients within Cheshire and Merseyside.

Personalised Care Dementia Nurse:
- Explore and define a Community/Primary Care Dementia Liaison Nurse role for cancer and/or end of life patients within Cheshire and Merseyside

5. Key Delivery Risks & Issues

Summary	Score	Mitigation
Demand and capacity issues affecting multi-agency working and engagement which is required for project delivery	8	Early identification and engagement with key stakeholders and priority alignment
Recruitment to Clinical Lead roles	8	Robust recruitment process
Increased data requirements to plan, monitor and implement projects (data availability, collection and interpretation) and insufficient capacity in the existing data Team at the Alliance	9	Recruitment to additional post part funded by Programme and utilising existing skills within the Team to support demand.
NHS organisational change may impact on sustainability of projects	9	Early engagement with Trusts, ICB and Place Based Systems
Capacity within the Alliance programme to support interdependencies with the Personalised Care Programme	8	Early engagement and involving wider teams in the planning
Projects delivery impacted by possible system pressures including industrial action, pandemics, seasonal or other external pressures on local Health System.	**9**	Workforce requirements and planning incorporated in project delivery plans, close liaison with partners around this.
There is potential for lack of capacity across the healthcare workforce for projects delivery	9	Clear capacity and demand modelling undertaken for workforce requirements for delivery and set out commissioned services.

2023/24 Personalised Care in Community and Prehabilitation Overview

Cheshire & Merseyside Cancer Alliance NHS

6. Programme Delivery – Projects

Project	Purpose
Programme Governance Personalised Care	Establish a Personalised Care programme forum Recruit to a Personalised Care Clinical Lead to support the delivery of the Personalised Care Interventions, Personalised Stratified Follow Up and wider Personalised Care Projects
Personalised Care in the Community	Explore how the learning from the evaluation of the Warrington community personalised care project and evaluation of the Cheshire community personalised care project can be developed into a Cancer Alliance wide plan to support more personalised care in the community closer to patient's homes.
Community/Primary Care Lead Cancer Nurse	Explore and define a Community/Primary Care Lead Cancer Nurse role to strategically support personalised care in the Community/Primary Care. Commence a Pilot role in Cheshire and Merseyside.
Dementia Liaison Nurse for Cancer Patients	Explore, define and assess the need for a dementia liaison nurse role for cancer and/or end of life patients within Cheshire and Merseyside. Commence a pilot of role.
Prehabilitation	Support Integrated Care Boards Prehab Strategy drawing on evidence and recommendations from evaluation of three pilots. Pilot a comprehensive prehab delivery model with offers at universal, targeted and specialised level in line with ICB Strategy. Review the recommendations from the ICB Approved CMAST paper setting out the strategic direction for Prehab across Cheshire and Merseyside. To explore the potential to pilot a comprehensive prehab model via defined expressions of interest process to invite Secondary/Tertiary Care Trusts. To implement an operational Prehab service with agreed metrics/KPI's/evaluation process.

2023/24 Personalised Care, PSFU and Psychosocial Support Overview

Cheshire & Merseyside Cancer Alliance

NHS

1. Programme Key Roles

Clinical Lead	TBD
SMT Lead	Tracey Wright
Senior Prog Manager	Sarah Houghton
Senior Project Managers	Jen Kelly

2. Programme Aim

This programme sets out the Cheshire and Merseyside Cancer Alliance plan to improve patient experience and cancer outcomes in Cheshire and Merseyside through personalised care.
Provide individualised care and support to cancer patients.
Reduce risks and improve long term outcomes and quality of life amongst those diagnosed with cancer.
Ensure a positive experience of care and support.
The aim contributes to the overall Long-Term Plan personalised care ambition that:
Where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support
Personalised stratified follow-up pathways are in place for people at the end of treatment so clear and appropriate follow-up plans are in place.
The importance of psychosocial support for people affected by cancer is widely recognised, and the Cancer Quality of Life survey has shown significantly higher rates of both mild and moderate mental health problems for those who have experienced a cancer diagnosis. There are known gaps in service provision, as identified by Cancer Alliances in their 2022/23 mapping and gap analysis work.
The impact of cancer will be tracked through the Quality of Life metric.

3. Background and Strategic Context

The NHS Long Term Plan outlines two key ambitions, this programme will support delivery of 55,000 more people each year that will survive their cancer for five years or more.

Personalised care has been identified as a key priority within the NHS Long Term Plan.
The plan sets targets for Personalised care to provide people with choice and control over the way their care is planned and delivered. This will empower people to manage their care and ensure they will have access to the right help and expertise to allow them to achieve better short and long term health benefits.

4. Programme Outcomes and Deliverables

Personalised Care:

- Ensure the following personalised care interventions are available for all cancer patients, and data is submitted to COSD for:
  - Personalised Care and Support Planning (PCSP) based on Holistic Needs Assessment (HNA)
  - End of Treatment Summary (EOTS)

PSFU:

- To support the implementation of fully operational and sustainable PSFU pathways for all suitable patients in breast, prostate, colorectal and endometrial cancer

Psychosocial Support:

- To deliver the Cancer Alliances' psychosocial support development plan.

5. Key Delivery Risks & Issues

Summary	Score	Mitigation
Demand and capacity issues affecting multi-agency working and engagement which is required for project delivery	8	Early identification and engagement with key stakeholders and priority alignment
Recruitment to Clinical Lead roles	8	Robust recruitment process
Increased data requirements to plan, monitor and implement projects (data availability, collection and interpretation) and insufficient capacity in the existing data Team at the Alliance	9	Recruitment to additional post part funded by Programme and utilising existing skills within the Team to support demand.
NHS organisational change may impact on sustainability of projects	9	Early engagement with Trusts, ICB and Place Based Systems
Capacity within the Alliance programme to support interdependencies with the Personalised Care Programme	8	Early engagement and involving wider teams in the planning
Projects delivery impacted by possible system pressures including industrial action, pandemics, seasonal or other external pressures on local Health System.	**9**	Workforce requirements and planning incorporated in project delivery plans, close liaison with partners around this.
There is potential for lack of capacity across the healthcare workforce for projects delivery	9	Clear capacity and demand modelling undertaken for workforce requirements for delivery and set out commissioned services.

2023/24 Personalised Care, PSFU and Psychosocial Support Overview

Cheshire & Merseyside Cancer Alliance

NHS

6. Programme Delivery – Projects

Project	Purpose
Personalised Care Inventions (PCI)	Ensure and support all Trusts to have implementation plans in place to support delivery of PCI to all patients and to improve performance across all sectors. Ensure all tertiary Trusts are submitting the Living Well and Beyond Cancer (LWBC) data to Cancer Outcomes and Services Dataset (COSD)
Personalised Care Principles (PCP)	To develop a set of HNA/PCSP principles agreed at local Cheshire and Merseyside level, potentially an output of the Lead Cancer Nurse Clinical Quality Group(CQG)-Personalised Care Working Group. Ensure local Standard Operating Procedures are in place at Trust/Provider level detailing the process for delivering and recording HNA/PCSP activity including relevant training.
Personalised Care Dashboard	Develop a CMCA Dashboard that shows; for example, the number of patients diagnosed; offered at HNA; PCSP and the Quality of Life Survey responses. This will be aligned to the national metrics.
Personalised Stratified Follow Up (PSFU)	Ensure all Trusts have fully operational and sustainable PSFU pathways for all suitable patients in: • Breast • Prostate • Colorectal • Endometrial Support outstanding Trusts to have fully operational and sustainable pathways for all suitable patients: • Prostate – East Cheshire NHS Trust • Colorectal – The Countess of Chester NHS Foundation Trusts Complete the implementation of 2022/23 PSFU protocols that were funded by CMCA. To address health inequalities and prevent digital exclusion, delivery of patient education will be reviewed to ensure the sessions are assessable and staff are aware of suitable adjustments which can be made to support patient engagement.
Psychosocial Support	Deliver the Psychosocial Development Plan which will include: • To improve engagement and understanding between roles, teams and services map the psychosocial pathways including known referral pathways. • Explore, define, and assess the need for a role which will have a holistic approach in reducing health inequalities by identifying people with pre-existing mental health problems and supporting access into and engagement with cancer services. Work with key stakeholders to identify the need, shape and define the role and remit.

2023-24 Primary Care Pathways Programme Overview

Cheshire & Merseyside Cancer Alliance NHS

1. Programme Key Roles

SMT Lead	Tracey Wright
Clinical Lead	Debbie Harvey
Senior Programme Manager	Liam Connolly
Senior Quality Improvement Manager	Louise Roberts

2. Programme Aim

Aim to save or extend more lives and improve quality of life for people affected by cancer across Cheshire and Merseyside (C&M) through working with primary care on the prevention and earlier detection of cancer agenda.

3. Background and Strategic Context

People diagnosed with cancer at an early stage have the best chance of curative treatment and long-term survival as well improve health outcomes, therefore prevention, early detection/early diagnosis are key to delivery.

Programme recognises the importance primary care has in supporting with delivery of NHS England's Long Term Plan to detect 75% of cancers at Stage 1 and 2 by 2028.

Strong leadership in primary care is required to facilitate change on a large scale. The developing Primary Care Engagement Team, which includes three Cancer Engagement Leads (CELs) and nine Place Based GP Leads (PB GPLs), goes some way to provide dedicated and expert support around the Primary Care Network Directly Enhanced Specification (PCN DES Spec), education and communities of practice.

4. Programme Outcomes and Deliverables

- Primary care will be provided with the expertise in order to implement the early cancer diagnosis components of their contracts which will enable patients to be diagnosed early and improve their short term and long-term health outcomes
- Provide Cheshire & Merseyside Cancer Alliance (CMCA) and primary care with a data dashboard to support with identifying opportunities for quality improvement and transformation
- Urgent suspected cancer referral quality and patient experience will be improved through implementation of new referral forms and templates
- Increased participation with the three cancer screening programmes
- Implementation of three Communities of Practice (COP) infrastructure, improving collaborative working for early cancer diagnosis
- Develop and deliver the primary care educational components of CMCA Cancer Academy, which will act as a repository and delivery arm for cancer education for C&M
- Model of education developed and delivered to primary care based on organisational and end user needs and requirements
- Implementation of safety netting for suspected cancer within practices across primary care
- Improvement of interface between primary care and CMCA people/programmes/projects
- Improve cancer outcomes across C&M population by identifying and supporting to address health inequalities

5. Key Delivery Risks & Issues

Summary	Score	Mitigation
Lack of stakeholder engagement and co-operation	9	Effective engagement with stakeholders outlining benefits of support. Plus alignment of stakeholder priorities and interface with CMCA programmes/projects
Projects delivery impacted by possible system pressures including industrial action, pandemics, seasonal or other external pressures on local Health System.	9	Workforce requirements and planning incorporated in project delivery plans, close liaison with partners around this.
PCN DES Spec has not yet been published for 2023/24. This may cause delays to programme design	8	CMCA has drafted a plan building on the work that commenced 2022/23. Assumptions have been made that the plan will not be too dissimilar to 22/23 requirements. Plan is flexible to accommodate adaptions post publication of 23/24 PCN DES Spec
Gaps in recruitment into the Primary Care Programme posts	9	Robust recruitment process, working with key Senior Managers within CMCA and across Places to support with recruiting to posts

2023-24 Primary Care Pathways Programme Overview

Cheshire & Merseyside Cancer Alliance NHS

Programme Delivery – Projects & Activity to support delivery	
Project/Activity	**Purpose**
Data Dashboard for Primary Care	Priority requirement in order to provide CMCA and primary care with up to date data to drive and deliver focused, data led transformation. Dashboard would include timely data covering; tumour specific, health inequalities, programme, screening, referrals and routes to diagnosis.
Primary Care Cancer Engagement	Provide strong Primary Care engagement and project management to CMCA, ensuring primary care perspectives are integral to CMCA strategic planning, pathway development and cancer services transformation. Provide optimum expertise to primary care to achieve implementation of early cancer diagnosis element 2023/24 PCN DES Spec. These roles will interface with CMCA Cancer Academy.
Programme Clinical Leadership	Introduce a GP Clinical Lead for overall clinical leadership of the Primary Care programme.
Place based GP Cancer Leads	Provide CMCA with Primary Care clinical leadership that facilitates engagement and relationships within a defined 'Place.' GPs will, on behalf of CMCA, work with practices around the areas of the PCN DES Spec, COP and will also support key areas of work at the Cancer Academy.
Evaluation	Evaluation of PB GPLs programme for impact and sustainability of roles. Evaluation of CELs to demonstrate impact of roles across Primary Care and to CMCA.
Primary Care Education/Interface with CMCA Cancer Academy	CMCA Cancer Academy is considered to be the 'go to place' for materials and educational training/resources to support primary care with the implementation of the prevention and early cancer diagnosis agenda. Ensure there is educational provision for primary care designed and delivered via CMCA Cancer Academy to support with PCN DES Spec early cancer diagnosis requirements.
Model of cancer education for GP Registrars	In collaboration with Health Education North West shape a model of education focusing on early cancer diagnosis for GP Registrars to ensure early cancer is featured in GP Registrar training.
Safety Netting Template	Provide primary care with an overview of the importance of safety netting for suspected cancer and also an electronic auditable solution to ensure patients with a high clinical suspicion of cancer are managed, reviewed and diagnosed in an efficient and safe manner
Urgent Suspected Cancer Referral Template	Provide primary care with EMIS (GP clinical software) templates. Patient experience will be enhanced by enabling rapid triage to the right test or service. Primary care clinicians will be supported with easily available referral guidance and information. Improvements in quality of referrals to secondary care trusts leading to improvements in early cancer diagnosis.
Clinical Decision Support (CDS) Tools	All GP practices across C&M region to have access to CDS tools via Ardens clinical template software.
GP Direct Access (GPDA) – Aligned to CMCA Diagnostic programme	A fifth of cancers are detected via routine GP pathways which involve longer wait times, delaying diagnosis for cancer patients. Implementation will allow faster investigation in those who fall just below NG12 threshold.
Cross Cutting Projects	Faster Diagnosis – Programme will support with promotion/interface of FD pathways e.g. FIT
	Cancer Academy – Programme interfaces with CMCA Cancer Academy in relation to development and delivery of education to primary care
	PED/PC – Programme interfaces with community engagement, screening and Grail
	Workforce – Programme interfaces with ACCEND programme plus health inequalities

2023/24 Genomics Programme Overview

Cheshire & Merseyside Cancer Alliance NHS

1. Programme Key Roles

Clinical Lead	Rosie Lord
SMT Lead	Tracey Wright
Senior Programme Manager	Stephen Jones

2. Programme Aim

To improve and modernise genomics pathways across Cheshire and Merseyside through engagement, education, and support of clinical teams, MDT's, pathology and the wider genomic system.
Fully engage with the Genomic Medicines Service Alliance in developing a shared workplan for cancer.
Ensure system leadership is in place to provide patients with a world class genomics service, treatment and testing.

3. Background and Strategic Context

The NHS England Strategy is based around delivering four priorities:

- Embedding genomics across the NHS, through a world leading innovative service model from primary and community care through to specialist and tertiary care
- Delivering equitable genomic testing for improved outcomes in cancer, rare, inherited and common diseases disease and in enabling precision medicine and reducing adverse drug reactions
- Enabling genomics to be at the forefront of the data and digital revolution, ensuring genomic data can be interpreted and informed by other diagnostic and clinical data; and
- Evolving the service driven by cutting-edge science, research and innovation to ensure that patients can benefit from rapid implementation of advances

4. Programme Outcomes and Deliverables

- Fully mainstreamed Lynch service to all patients diagnosed with colorectal or endometrial cancers.
- Successful pilot of the Galleri Grail project, with evaluation and benefits realisation.
- Fully mapped exemplar pathway, and 3 priority tumour pathways, and across the North-west. With clear plans for optimal pathway improvement.

5. Key Delivery Risks & Issues

Summary	Score	Mitigation
Multi-partnership working is required across all projects to deliver	8	Early identification and engagement with key stakeholders and priority alignment
Projects delivery impacted by possible system pressures including industrial action, pandemics, seasonal or other external pressures on local system.	9	Workforce requirements and planning incorporated in project delivery plans, close liaison with partners around this.
Projects may not meet full potential if funding for incremental years of the programme not allocated in due time or programme deliverables do not continue to justify the further investment	9	Funding for next two years is confirmed. KPI & project performance analysis as core part of project delivery plan and evaluation and demonstration of outcomes.
Potential lack of capacity across the Health Workforce for programme delivery.	9	Capacity and demand modelling undertaken for delivery and clearly set out to commissioned services.

6. Programme Delivery – Projects & Activity to support delivery

Project	Purpose
Grail	To determine whether the Galleri test can accurately and reliably detect cancer in people who aren't suspected as having cancer and if it can find cancer at earlier stages than would otherwise have been the case, as part of a pilot study for the national NHS England-GRAIL Screening Study Partnership.
Lynch – Colorectal and Endometrial	To improve the stage of diagnosis for people who develop colorectal or endometrial cancer by detecting more people with lynch syndrome that may be symptom free, or have a family history of either colorectal or endometrial cancer. To conduct an audit to ensure compliance with the pathway is being adopted.
IMPACTT	Lead on a North West programme of molecular pathway mapping to determine variances in Turnaround Times. To further identify blocks and barriers in the system, and support pathway improvements, and improved patient outcomes.
Clinical & CQG Leadership	To provide system level support and guidance in adopting best-practice in regards to genomics, and encourage full adoption of appropriate pathways.

2023/24 Treatment Variation Programme Overview

Cheshire & Merseyside Cancer Alliance NHS

1. Programme Key Roles

Clinical Lead	Chris Warburton
SMT Lead	Tracey Wright
Senior Prog Manager	Sarah Houghton
Senor Project Manager	Sue Renwick

2. Programme Aim

The programme aims to reduce treatment variation in three of the areas identified in the National Lung Cancer Getting it Right First Time (GIRFT) report and one area in each of the four National Cancer Clinical Audits for breast, prostate, and bowel cancer.

3. Background and Strategic Context

The NHS Long Term Plan outlines two key ambitions, this programme will support delivery of 55,000 more people each year that will survive their cancer for five years or more. Reducing variation in cancer treatment delivery for the areas outlined in the project aim and improving delivery towards best practice whilst working to reduce any inequalities identified within the treatment variation delivery

4. Programme Outcomes and Deliverables

To implement the three selected Lung GIRFT lung cancer report recommendations and one priority recommendation from each of the 4 existing clinical audits for cancers other than lung cancer.
To engage Clinical Quality Groups (CQGs) around treatment variation and support trusts to put in place data collection to monitor progress.
Undertake data reporting against the recommended targets and gain feedback on barriers to improved performance and support trusts to test ideas to improve performance across Cheshire and Merseyside.
CMCA to champion timely access to diagnostics and treatment across the local system.

5. Key Delivery Risks & Issues

Summary	Score	Mitigation
There is the potential to not obtain trust level data on cancer treatment as this is complex and labour intensive to collate and is systems used across the region are different.	9	Gain feedback from one trust who gained data for one quarter, understand the staff time skill and capacity to deliver regular reporting.
There is a risk that assumptions are made regarding variations in treatment choices.	9	Gain insight from patients for treatment variation choices. Gather feedback on reasons for treatment variation and common themes and capacity bottlenecks in the local system to achieve improvement. CMCA to engage with wider partners and champion access to diagnostics and treatment within the local system.
Multi-partnership working is required across all projects to deliver. There is risk of non engagement with the programme. A whole team approach is required to maximise the opportunity to change pathways - clinical champions, data collation and project management all required to deliver implementation.	8	Early identification and engagement with key stakeholders and priority alignment CMCA to utilise both internal and external resources to support to enable a whole team approach and varying intensity of support to the local requirements.
Projects delivery impacted by possible system pressures including industrial action, pandemics, seasonal or other external pressures on local Health System.	**9**	Workforce requirements and planning incorporated in project delivery plans, close liaison with partners around this.
Potential for lack of capacity across the Health Workforce for programme delivery.	**9**	Clear capacity and demand modelling undertaken for delivery and clearly set out to commissioned services.

6. Programme Delivery – Projects

Project	Purpose
Lung Getting It Right First Time (GIRFT) report.	To continue to oversee the implementation of 3 selected treatment recommendations from the national lung Getting It Right First Time (GIRFT) report. 1. Pathological services should provide a maximum ten calendar day turnaround time for molecular profiling according to the national test directory of lung cancers to meet the requirements of the NOLCP. 2. All trusts should have an overall radical treatment rate of 85% or more in those patients with NSCLC stages I-II and of performance status 0-2. This includes all treatment modalities (surgery, radiotherapy including SABR, multimodality treatment and thermoablative techniques). 3. All trusts should have an overall surgical resection rate for NSCLC of over 20%.
Bowel	Reduce variation in neoadjuvant radiotherapy treatment in rectal cancer patients undergoing resection. Ensure evidence-based local radiotherapy policies are in place.
Prostate	Investigate why men with high-risk/locally advanced disease are not considered for radical treatment.
Breast	Breast cancer surgical teams should examine their reoperation rates after breast conservation surgery to identify areas where reoperation rates can be reduced, whilst supporting safe breast conservation.

2023/24 Prevention and Timely Presentation Programme Overview

Cheshire & Merseyside Cancer Alliance NHS

1. Programme Key Roles	
Clinical Lead	Debbie Harvey & Gareth Jones
SMT Lead	Tracey Wright
Senior Programme Managers	Stephen Jones & Liam Connolly
Senior Project Managers	

2. Programme Aim

To continue to make progress in delivering improvements in early diagnosis to support delivery of the Long Term Plan's ambitions so that more people each year will survive their cancer for five years or more; and more people with cancer will be diagnosed at an early stage (stage one or two) To improve cancer outcomes prevention, early detection and early diagnosis are key to delivery. People diagnosed with cancer at an early stage have the best chance of curative treatment and long-term survival as well improve health outcomes.

3. Background and Strategic Context

To improve cancer outcomes prevention, early detection and early diagnosis are key to delivery. People diagnosed with cancer at an early stage have the best chance of curative treatment and long-term survival as well improve health outcomes.
Despite cancer screening programmes, improved awareness, and faster diagnostic pathways, only 54% of patients with cancer in England had their cancer detected early (at Stage 1 and 2) in 2018. NHS England's Long Term Plan sets a target to detect 75% of cancers at Stage 1 and 2 by 2028. Expansion of the Targeted Lung Health Check model is a key enabler of this. This means an extra 55,000 people each year will survive cancer for five years or more following their cancer diagnosis if this improvement is met.

4. Programme Outcomes and Deliverables

- More people supported to make healthier lifestyle choices (specifically around smoking and obesity) reducing risk factors for associated cancers.
- Fewer people being diagnosed with preventable cancers (Reduce growth number of all cancer cases)
- More people surviving for longer after a diagnosis (Improve survival from cancer - one, five and ten years)
- More people having a cancer diagnosed at an early stage (Cancer staging) in line with NHS Long Term Plan.
- More people engaging in cancer screening programmes (Increase in cancer screening uptake)
- Reduce mortality from lung cancer through a targeted invitation to a lung health check and increasing number of checks and scans taken across the region.
- The overall programme to align with 2023/24 NHSE planning guidance: Early Diagnosis

5. Key Delivery Risks & Issues

Summary	Score	Mitigation
Multi-partnership working is required across all projects to deliver	8	Early identification and engagement with key stakeholders and priority alignment
Projects delivery impacted by possible system pressures including industrial action, pandemics, seasonal or other external pressures on local Health System.	9	Workforce requirements and planning incorporated in project delivery plans, close liaison with partners around this.
Projects may not meet full potential if funding for incremental years of the programme not allocated in due time or programme deliverables do not continue to justify the further investment	9	Funding for next two years is confirmed. KPI & project performance analysis as core part of project delivery plan and evaluation and demonstration of outcomes.
Potential for lack of capacity across the Health Workforce for programme delivery.	9	Clear capacity and demand modelling undertaken for delivery and clearly set out to commissioned services.

2023/24 Prevention and Timely Presentation Programme Overview

Cheshire & Merseyside Cancer Alliance NHS

6. Programme Delivery – Projects & Activity to support delivery	
Project	**Purpose**
Tobacco Control; CURE Outpatients pilot	To reduce smoking related harm by leading and supporting a system wide approach, and creating targeted activities to promote, encourage & empower people to stop smoking. This includes piloting a cancer pre-operative variation of the CURE programme targeting one or two Trust(s) and departments particularly impacted by smoking harms
Tobacco Control; Tuberculosis Cessation	A project targeting vulnerable patients with Tuberculosis (TB) supporting TB clinical team to develop system to refer TB patients to smoking cessation, breaking down barriers with a population that are typically disengaged from the Health system.
Tobacco Control; Paediatric Smoking Project	To continue the work developed with Alder Hey Children's Hospital to tackle smoking in Children and Young People, targeting parents and carers of children who suffer smoking related harm. This will include evaluating the longer term impact of the project.
Obesity (Strategic)	Reducing obesity as a risk factor for cancer and improving outcomes following cancer diagnosis. By engaging in a whole systems approach to promoting, encouraging and empowering people to have healthier lifestyles.
Obesity (Secondary)	Delivery of a "Moving Medicines" project (A NHS Tool to support clinicians to engage patients with resources to address overweight and obesity) project with Alder Hey Paediatric Trust.
Targeted Lung Health Checks (Targeted Case Finding)	Reduce mortality from lung cancer through a targeted invitation to a lung health check and where appropriate a Low Dose CT scan, in three localities with the highest mortality and inequalities from lung cancer. 2023/24 will see the roll out of targeted invitations to three further places increasing Cheshire and Merseyside's eligible population coverage to 69% by year end (from current reach of 42%). Planning will continue to reach 100% coverage by end of 2024/25 financial year.
Timely Presentation Campaigns	Develop a campaign, communications and social media function within the timely presentation workstream, to drive large-scale awareness raising and screening uptake, building on existing national, regional, and local resources and campaigns as well as creating bespoke locally-tailored resources for Cheshire and Merseyside

2023/24 Prevention and Timely Presentation Programme Overview

Cheshire & Merseyside Cancer Alliance NHS

Project	Purpose
Community Engagement	Working with Community and Voluntary organisations across the nine Places to target areas of inequality, engagement with public and partners to act upon possible early signs and symptoms of cancer through an Anchor Institute approach. Empower patients to understand and present early with possible signs and symptoms of cancer, with a targeted focus on vulnerable communities to reduce the variation in outcomes within the population and allow more people to be diagnosed and treated earlier. Deliver an in-depth evaluation of the project.
Innovations	To improve early diagnosis of pancreatic cancer and reduce health inequalities within this population continuing with 2022-23 project as part of the EUROPAC trial. In addition to Europac-plus CMCA will develop and deliver an action plan to support with the national requirement for case finding. To improve early diagnosis of Oesophageal cancer using an innovative approach and developing new solutions. To improve earlier diagnosis through working with Primary Care to identify an area to implement innovative practice. To improve patient outcomes through identifying and piloting innovative approaches to early diagnosis and personalised care.
Clinical Leadership	(Tobacco Control and Public Health) To provide expert clinical guidance to inform on projects, engage and influence stakeholders to support delivery of tobacco control and Population Health projects within the programme

2023/24 Screening Programme Overview

Cheshire & Merseyside Cancer Alliance NHS

1. Programme Key Roles

Clinical Lead	Debbie Harvey
SMT Lead	Tracey Wright
Senior Programme Manager	Stephen Jones, Liam Connelly
Senior Project Manager	Louise Roberts

2. Programme Aim

- Develop and implement targeted approaches to increase uptake across the footprint within all screening programmes safely and in a way that doesn't overwhelm recovering services
- Deliver national changes and programme priorities in partnership with regional NHSE Screening and Immunisations team

3. Background and Strategic Context

People diagnosed with cancer at an early stage have the best chance of curative treatment and long-term survival as well improve health outcomes.
Despite cancer screening programmes, improved awareness, and faster diagnostic pathways, only 54% of patients with cancer in England had their cancer detected early (at Stage 1 and 2) in 2018.
NHS England's Long Term Plan sets a target to detect 75% of cancers at Stage 1 and 2 by 2028.
This means an extra 55,000 people each year will survive cancer for five years or more following their cancer diagnosis if this improvement is met.

4. Programme Outcomes and Deliverables

- More people surviving for longer after a diagnosis (Improve survival from cancer - one, five and ten years)
- More people having a cancer diagnosed at an early stage (Cancer staging)
- More people engaging in cancer screening programmes (Increase in cancer screening uptake)
- The overall programme to align with 2022/23 NHSE planning guidance: Early Diagnosis sections 1 and 2
- Primary Care provided with the expertise necessary to implement the screening element of the 2023/24 PCN DES
- Multidirectional improved visibility and sharing of cancer related data and soft intelligence to underpin cancer screening outcomes

5. Key Delivery Risks & Issues

Summary	Score	Mitigation
Multi-partnership working is required across all projects to deliver	8	Early identification and engagement with key stakeholders and priority alignment
Projects delivery impacted by possible system pressures including industrial action, pandemics, seasonal or other external pressures on local Health System.	9	Workforce requirements and planning incorporated in project delivery plans, close liaison with partners around this.
Projects may not meet full potential if funding for incremental years of the programme not allocated in due time or programme deliverables do not continue to justify the further investment	9	Funding for next two years is confirmed. KPI & project performance analysis as core part of project delivery plan and evaluation and demonstration of outcomes.
Potential for lack of capacity across the Health Workforce for programme delivery.	9	Clear capacity and demand modelling undertaken for delivery and clearly set out to commissioned services.

6. Programme Delivery – Projects & Activity to support delivery

Project	Purpose
Local Maternity Service cervical screening project.	Delivery of training to midwifery workforce to increase effective engagement and referral into Primary Care screening services, with a measurable increase in uptake of cervical screening.
Screening Project Manager	• Provide CMCA with an interface for all programmes relevant to screening programmes. • Provide opportunity for partnership working with PHE Screening and Immunisations team, providing a focus on data development/sharing across the network, plus provide oversight of all screening initiatives across C&M. • Education provision across primary care covering cancer screening programmes.

2023/24 Workforce Programme Overview

Cheshire & Merseyside NHS

1. Programme Key Roles

SMT Lead	Greg O'Mara
Senior Programme Manager	Sarah Atherden

2. Programme Aim

- Support our cancer workforce to **reach their full potential** through the delivery of training and education
- Provide a **standardised approach to cancer education** delivery in collaboration with educational partners
- Proactively support the **health and well-being** of our cancer workforce and continuously improve equality, diversity and inclusion
- **Attract, recruit and retain** people within Cheshire & Merseyside, to secure the skills and people needed across our system for the future
- Support the transformation of our workforce to respond to new challenges, **deliver new ways of working** and offer the best possible patient care

3. Background and Strategic Context

This programme aligns with the main workforce priority areas highlighted in the NHS Long Term Plan, the NHS People Plan, the Cancer Workforce Plan and the Diagnostics: Recovery and Renewal report.

NHS People Plan 2020/21: actions for us all, published in 2020, sets out practical actions with specific commitments:

- **Looking after our people** with quality health and wellbeing support for everyone
- **Belonging in the NHS** with a particular focus on tackling the discrimination that some staff face
- **New ways of working and delivering care** making effective use of the full range of our people's skills
- **Growing for the future** how we recruit and keep our people, and welcome back colleagues who want to return

Diagnostics: Recovery and Renewal - Sir Mike Richards Oct 2020 report, recommended a new diagnostics model, and elements are being taken forward by the C&M CDC and wider ICS Diagnostic programmes. Significant implications for the capacity and capability of the cancer and diagnostic workforce.

The 23/24 NHS National Planning Guidance also reiterates the integral part workforce plays to ensure success of all cancer related programmes and activity.

4. Programme Outcomes & Deliverables

The 2023/24 Workforce programme has four core objectives:

1 Growing the Workforce – Continuing to support the growth of priority cancer workforce groups, engaging at national and local level to ensure interdependencies with key stakeholders are mapped eg, other Alliances, National Cancer Programme, C&M Diagnostics Delivery Board, NW Diagnostics Workforce Programme

2 Recruitment/Retention – Work with newly established NHSE and local systems to ensure we have the right numbers of skilled staff to provide high quality care and services to cancer patients at each stage in their care. Ensure the health and well-being of our workforce is prioritised and work at local and national level to provide appropriate support to ensure the retention of the cancer workforce.

3 New roles/New ways of working – Support workforce transformation and introduce new ways of working to deliver the best possible patient care. Continue to deliver the education required to ensure we have a skilled and competent cancer support workforce.

4 System-working - Work in partnership with the ICS, regional Clinical Networks, to increase cancer workforce capacity through system-led initiatives.

5. Key Delivery Risks & Issues

Summary	Score	Mitigation
Capacity of system to engage in workforce development projects	9	Continue to support and review as required. Collaboration across C&M & regional initiatives
Expansion of programme without resources to support	9	Recruitment underway for HEE national PCCP roll-out and temporary project management in place. Additional clinical support also being secured. Senior Programme Manager being recruited.

6. Programme Delivery – Projects & Activity to support delivery

Projects	Purpose
Cancer Academy	Our Cancer Academy will continue to grow. It will offer Health Inequality workshops to the cancer workforce, educating the workforce in how to tackle health inequalities. We will support the delivery of the updated DES to the Primary Care workforce, also creating a specialist area within the Primary Care section expanding on FIT related information and guidance. We will focus on ARRS training and education with a view to offer a customised version of the Principles of Cancer Care Programme (PCCP) and ensure alignment to the HEE ACCEND programme. The Cancer Academy will also directly support delivery of the PCCP at a national level. We will continue to plan and prioritise requests for support from internal and external stakeholders.
HEE ACCEND	We will continue to programme manage and administrate the national training, education and career framework for the assistive and supportive workforce through HEE ACCEND. Funded by HEE, we will lead the delivery of 17 national cohorts of the PCCP training for our assistive and supportive workforce during 23/24. We will start to plan delivery of a 'Train the Trainer' programme, which will commence from April 24, with CMCA starting to train the other 20 Cancer Alliances in the delivery of the PCCP, to take forward this standardised programme for their own regions, ensuring sustainability and consistency of delivery. From April 2024, we plan to take ownership of the Enhanced Communications Skills training from the current provider (Frontline) to deliver directly through the Alliance and will commence the planning and preparation for this in 23/24.
Speech and Language Therapy system approach to deliver Head & Neck Cancer	We will support and co-ordinate a workforce modelling exercise in relation to Speech and Language Therapy (SaLT) services. The aim is to identify future and sustainable workforce models for the service but also test our approach and provide a working model to then use and adapt for other cancer services and pathways. Following the provision of CMCA funding in 22/23 for development of a competency framework and delivery of an education programme, we will work closely with system colleagues as these are developed to provide input and advice and regularly monitor progress against plan.
Cancer Services Teams	We will work with our cancer services teams to develop and lead a review of existing services, to identify a proposed sustainable workforce model for further discussion with our key partners and stakeholders in C&M.
MDT Coordinator Training	Continue the regional implementation and funding for all MDT Coordinators to have access to an online eLearning solution, that will support and improve their knowledge around Cancer Waiting Time rules, cancer standards and patient pathways.
System working	We will: • Continue to support the distribution of funding provided via external source to develop & grow the cancer workforce • Provide support and advice to a Gynae services workforce modelling review and future state proposal • Support the development of workforce plans for key cancer workforce groups, engaging with key stakeholders to take forward e.g. Lead Cancer Nurses • Support all CMCA programmes with workforce advice, direction and support to ensure alignment with national and regional workforce priorities and plans

23/24 Health Inequalities and Patient Experience (HIPE) Programme Overview

Cheshire & Merseyside Cancer Alliance — NHS

1. Programme Key Roles

SMT Lead	Greg O'Mara
Programme Manager / HIPE Lead	Sarah Atherden / Jo Trask

2. Programme Aim

To:

- Create the necessary infrastructure to embed patient engagement and the use of patient experience and health inequalities insights across CMCA programmes and regional health settings to ensure they are inclusive and representative of the Cheshire and Merseyside population,
- Reduce health inequality for vulnerable communities within Cheshire and Merseyside and involve a variety of patient voices in the development of, rolling out and upkeep of CMCA led projects to ensure they remain in touch with local populations needs. This will include working with PCN's and Trusts to roll out good practice.
- Develop infrastructure to support CMCA in building a strong network of confident health providers across Cheshire and Merseyside, tackling health inequality and engaging diverse patient voices at all stages of development and delivery so that it is inclusive of the needs of the Cheshire and Merseyside population.

3. Background and Strategic Context

Patient Involvement and tackling Health Inequalities are cited as priorities in the NHS LTP and the 23/24 Cancer Alliance Planning Pack. There is a national expectation of Cancer Alliances to engage in this agenda, involving patients and maintaining a focus on patient experience and health inequalities at all stages of transformation, from prioritisation, planning and service design through to implementation and evaluation to ensure that improvements are inclusive and aligned to the local populations needs. Cancer is also included in the Core20+5 agenda, to tackle Health Inequality.

The HIPE team at CMCA, will further develop the infrastructure both within CMCA and across our area to better engage patients within our governance structure and to support the understanding and use of health inequalities and patient experience insights across our programmes and projects to improve outcome for an inclusive population across the region. The team are widely regarded, and are providing strategic and practical support at a national level also.

4. Programme Outcomes & Deliverables

- Recruitment and retention of diverse patient representatives
- Further development of the engagement network around current and future patients representatives
- Tackling Health Inequality is embedded as part of the PMO structure
- Patient Engagement and Involvement Policy and process is embedded across our organisation, ensuring patients are consulted at all stages of the project lifecycle, where appropriate
- Develop further connections with our communities
- Provide support and training within CMCA and across trusts to raise the profile of health inequalities and patient experience, as part of the 123 approach
- Provide Health Inequality training for the Cheshire and Merseyside cancer workforce, as part of the Principles of Cancer Care Programme (PCCP) and The Cancer Academy
- Increase diversity amongst those consulted and seek out a range of views
- Deliver communication and engagement activities to achieve a Quality of Life survey response rate >50% and increase uptake within underrepresented groups
- Measure % staff trained, % projects with patient input and delivery of 8 roadshows

5. Key Delivery Risks & Issues

Summary	Score	Mitigation
Lack of diversity within patient and community groups, meaning all views/needs are not considered within projects/services in making quality improvements for an inclusive population.	9	Engagement project. Roadshows will focus on areas of inequality not yet represented. Represent HIPE at all Programme Forums.
Project Managers not embedding HIPE into their project management process so that projects are not inclusive of vulnerable communities leaving an inequity in cancer care and services.	9	Ensure processes around tackling health inequality and involving patients are co-produced with CMCA team and embedded in PMO process. Areas of concern are identified and HIPE team create solutions, making processes straightforward.
HIPE approach is not embedded across local system in relation to cancer, thereby putting vulnerable communities at risk of late stage diagnosis.	9	Multi-partnership working. Early identification and engagement with key stakeholders and priority alignment across CMCA and Cheshire and Merseyside. Develop a clear programme outline and agreed delivery plan. Staff Network.

6. Programme Delivery – Projects & activity to support delivery

Project	Purpose
Patient Engagement	This function will: • Ensure communications are suitable for the general public by embedding the 'Reader's Panel' (and 'Easy Reader's Panel') to review public-facing documents, encouraging staff to use this • Continue to support Project Managers to include planning around patient experience throughout the project lifecycle • Create an annual plan for CPES including information sessions for lead cancer nurses, breakdown of results and support when needed • Work with the CMCA Community Engagement team to involve a wider network of community organisations to ensure community voice is incorporated into the engagement offer
Diverse patient and carer representatives	To continue to recruit diverse patient and carer representatives to input into CMCA projects and plans to ensure they are inclusive of the population in Cheshire and Merseyside. We will: • Develop an efficient governance system, including training and expenses, for involving patients, carers, and public representatives to ensure the sustainability of patient support and in recognition of the additional time and support required for our diverse representatives • Design a system to capture deliverables for reporting purposes • Develop a patient representative forum with messaging and sharing features • In conjunction with other CMCA programmes, identify barriers people face during screening and promote an understanding of these barriers • Develop after treatment support options in conjunction with lived experience patients
Embedding HIPE into CMCA and partners	Increase action in tackling health inequality across Cheshire and Merseyside by: • Ensuring CMCA are confident and supported to act against health inequalities and to engage with the patient and/or community voice • Developing the HIPE champion offer (internally) and HIPE Staff Network (externally) to ensure training, development and support are offered as standard. The library of resources will be expanded and reviewed, with a comms plan of promotion, to promote across the area. • Ensuring all programmes receive regular input on plans through forums and impact assessments to ensure HIPE is integral to approach
Develop 123 approach	The *Resources*, *Training*, *Support* approach is to be developed into the *123 approach*. Offering great resources, HIPE workshops and a staff support network to follow. The approach will be branded as a resource and rolled out across Cheshire & Merseyside
Roadshows	To create opportunities for involvement and co-production with the general public, with a focus on areas of inequality, enabling CMCA to raise the profile of the organisation; collect real-time data as to how people are feeling about cancer services in their local area; listen to and capture patient stories; recruit patients, carers and public members to a variety of volunteer roles with CMCA; and create an opportunity for CMCA staff to interact with the public for the benefit of their particular project. The second round of roadshows will aim to build on the first. The locations will correspond with any gaps in demographics from our current patient representative cohort.
Community Partners	To support two small community projects funded by CMCA: • One Knowsley Lung Cancer Community Programme. This was originally due to complete in March 23 but has been extended until September 23 for added recruitment and delivery time. An evaluation will then be produced in Q3 • To fully develop the WHISC (Women's Health and Information Centre) project and subsequent evaluation
Surveys	To improve services and patient experience for adults and children under 16s accessing cancer services through promotion of, and acting upon the results of, national annual cancer surveys including the National Cancer Patient Experience Survey, Under 16 Cancer Patient Experience Survey and Quality of Life Survey. To provide results to regional teams and to maintain a rolling comms programme to increase uptake levels.

Dr Liz Bishop
Senior Responsible Officer
liz.bishop1@nhs.net

Jon Hayes
Managing Director
jon.hayes1@nhs.net

Dr Chris Warburton
Medical Director
chris.warburton@liverpoolft.nhs.uk

Dr Debbie Harvey
Primary Care Lead
debbie.harvey1@nhs.net

Website: www.cmcanceralliance.nhs.uk
General Enquiries: ccf-tr.admin.cmca@nhs.net

Cheshire and Merseyside
Cancer Alliance

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NHS Cheshire and Merseyside Integrated Care Board Meeting

30 March 2023

Report of the Quality & Performance Committee Chair

Agenda Item	**ICB/03/30/17**
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		
Recommendation	**The Board is asked to:** • Section 2 note the content • Section 3 note the content and the issues considered by the Committee and actions taken. • Section 4 Consider the matters escalated to the ICB Board				
Key issues	Outlined within the report				
Key risks	Outlined within the report				
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:

Decision Log Ref No.	Meeting Date	Issues considered
23/02/05	16/02/23	**LeDeR Quarterly Update** The committee was presented with an update from the LeDeR team regarding the national programme and how changes relating to the establishment of ICBs are underpinning the national LeDeR policy which has moved accountability to ICB. As well as a move towards a more in-depth focus of those from ethnic minority groups. A combined workforce model has been implemented with Greater Manchester ICB; there is now a shared group of leaders. A full governance structure is undergoing evaluation and work will take place on membership to represent all the sectors at senior leadership level to ensure wider level of challenge and scrutiny.
23/02/11	16/02/23	**Quality and Performance Dashboard** The Committee was updated on the level of challenge faced by the system including planned and unplanned care. The committee noted the positive expansion of reporting in relation to Primary Care and how this will be further developed. The committee noted the ongoing work to ensure that aspects of social care activity and performance needs to be better reflected to ensure full system view.
23/02/12	16/02/23	**Place Based Key Issues Report** The Committee had a focus on those places within The North Mersey footprint and heard from colleagues from Liverpool place in relation to the publication of historical incidents that have generated independent reviews. The committee was presented with detail and assurance as to steps taken regarding two case of mental health homicide and the investigations and learning that have been undertaken. Publication dates were discussed, and the committee was assured by the actions taken to ensure state of readiness for publication. The Committee was presented with a report that detailed the work undertaken to secure quality improvement

Decision Log Ref No.	Meeting Date	Issues considered
		following the Rapid Quality Review of services for Cheshire and Wirral Partnership. Place based leads are working closely with the organisation to ensure and seek assurance from both the organisation and the wider system as to actions taken to improve, Ongoing reporting will continue as to progress via the Committee.
23/02/09	16/02/23	**Risk Register Update** The Committee was informed and assured of the ongoing work to develop a corporate approach concerning risks to quality and safety. This will form part of standard reporting at each committee meeting.
23/02/07	16/02/23	**Patient Safety** The Committee received its quarterly report relating to Patient Safety and the state of readiness for transition to the national Patient Safety Incident Response Framework. Further work was recognised as being needed to ensure the close down of the Serious Incident Framework and closure of legacy investigations which is being led by place based teams and respective providers.

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
23/02/14	16/02/23	**Clinical Effectiveness Group Terms of Reference** The Committee approved the Terms of Reference for the newly established Clinical Effectiveness Group. The group will act as an advisory group in relation to evidence-based interventions and associated quality improvement. The group may make recommendations to the Committee should it be determined that there are changes required to clinical pathways and processes to improve quality, safety and the effectiveness of care provision.

4. Issues for 4. 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
23/02/06	16/02/23	**Infection Prevention & Control (IPC)** The committee was presented with its quarterly report into IPC governance and performance for the ICB/S. The Committee recognised the need for greater pace in establishing robust oversight in this area. A workshop will take place in March 2023 to reframe and refocus the work as to how IPC and the associated Anti-Microbial Resistance work programme will operate in the future.
23/02/10	16/02/23	**Local Maternity and Neonatal System** The Committee received its monthly report by exception in relation to maternity services in C&M. The Committee was informed that Liverpool Women's Hospital had received an inspection by the Care Quality Commission and concerns were noted in relation to maternity triage and risk assessment provision. Further detail will be included in the more comprehensive update to be provided at the March 2023 committee, with the assurance that the provider had taken steps to mitigate any immediate risks to patient safety.
23/02/04	16/02/23	**Northwest Ambulance Service (NWAS) & System Pressures** The Committee received a report from the Director of Quality at NWAS in relation to patient safety because of system pressures during the month of December 2023. The Committee was informed that due to delays in ambulance response times, patients may have incurred harm, with all incidents under investigation. The Committee discussed how the fuller detail of this report would be discussed at Board level and any associated actions to be taken would form part of the wider programme of work within C&M aimed at improving response times and reducing ambulance handover delays.

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:**

- Section 2 note the content
- Section 3 note the content and the issues considered by the Committee and actions taken.
- Section 4 Consider the matters escalated to the ICB Board regarding:
  - Infection Prevention & Control Governance & Oversight
  - the Care Quality Commission inspection at Liverpool Women's Hospital
  - The work to improve ambulance response times and reduce handover delays.

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

30 March 2023

Report of the Audit Committee Chair

Agenda Item No	**ICB/03/30/18**
Report author & contact details	Matthew Cunningham, Associate Director of Corporate Affairs & Governance
Report approved by (sponsoring Director/ Chair)	Neil Large, Chair of the Audit Committee
Responsible Officer(s) to take actions forward	Claire Wilson, Executive Director of Finance Mark Bakewell, Deputy Director of Finance Matthew Cunningham, Associate Director of Corporate Affairs and Governance

Cheshire and Merseyside ICB Board Meeting

NHS Cheshire and Merseyside

Report of the Audit Committee Chair

Executive Summary	The Audit Committee of the NHS Cheshire and Merseyside Integrated Care Board met on 07 March 2023. The meeting was quorate and was able to undertake the business of the Committee. Declarations of interest where applicable where minuted. Main items considered at the meeting via papers received or verbal update provided included: • paper on ICB Procurement Waivers December 2022- February 2023 • a paper on Losses and special payments • a paper outlining management responses – Informing the audit risk assessment • an update on the development of the Annual Report and Accounts 2022-23 • ICB Risk Management Update • ICB Declarations of Interest Progress Update • Internal Audit progress report • Counter fraud update report • a paper from the ICB on a supplier Set-Up Fraud • a paper from the Anti-Fraud team regarding an Interim Investigation Report regarding a Supplier Set-Up Fraud • External Audit plan (part year CCG)/ICB progress report • Bi-monthly Information Governance Update Report • an update on progress regarding the DSPT baseline Submission assurance. The next meeting of the Committee is scheduled to be held on 18 April 2023.

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 Audit Committee at its meeting on the 07 March 2023.

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	There were no declarations of interest made by Members or attendees at the meeting that would materially or adversely impact on matters requiring discussion and decision.
Next Steps	None
Appendices	None

Report of the Audit Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
Audit Committee (Statutory Committee)	The main purpose of the Committee is to contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.	Neil Large, 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
	07.03.23	**ICB Procurement Waivers** The Committee received a paper that provided an update on the tender waivers approved by the ICB Executives and its various Place Directors / Associate Finance Directors between December 2022 and February 2023. During this time, there had been six tender waivers approved, totaling close to £10m, that had either been reviewed and approved by the ICB Executives or Place Senior Leadership Team, in line with the ICB SORD limits The Committee noted the reasons for the six waivers, and also noted the intention to publish the waivers on the procurement decision register on the public facing website.
	07.03.23	**Annual Report and Accounts 2022 - 2023** Committee members received an update on the ICB's timetable for the completion of the 2022/23 Annual Accounts and highlighted key requirements/changes notified in this year's DHSC Group Accounting Manual (GAM) 2022/23. Committee was informed that there had been no major changes in the GAM other than the removal of policies that did not apply to ICBs. The Committee also reviewed and noted the accompanying draft Accounting Polices to the report,

Decision Log Ref No.	Meeting Date	Issues considered
		recognising that these were still draft and required further review following the release of national guidance. The Committee also reviewed the management response and within the paper regarding the assessment of the preparation of the financial statements and agreed that it continues to be a "going concern" based upon the responses provided. The Committee noted the report and is due to receive further detail on the draft set of accounts and the annual report at its April meeting prior to the submission of the first draft to NHS England.
-	07.03.23	**ICB Declaration of Interest Update**. Committee members received its regular update on the ICBs work around implementing the ICBs Conflicts of Interest (COI) Framework, and the population of and management of its COI registers. An update was given regarding the development of a dedicated Declarations of Interest section on the ICB Staff Hub and the roll out of an online form that will help capture individual staff confirmation of them reading the ICB Conflicts of Interest Policy and understanding of their responsibilities around declaring nay interests. The Committee noted the update report and will receive a further update at its next meeting.
-	07.03.23	**ICB Risk Framework Development.** Committee members received an update on the development and approval of the ICB Risk Framework, and risk appetite statement by the Board at its meeting in February 2023. The Committee was updated on the next steps in developing the Board Assurance Framework and its principal risks, with the ICB Board due to receive this at its meeting in April 2023. The Committee was also informed around the development of an ICB Risk Committee that will help to oversee the implementation of the ICBs risk arrangements and development of system risk work.

Decision Log Ref No.	Meeting Date	Issues considered
		This Committee will not replace the role and function of the audit committee with regards risk. The Committee noted the update report and will receive a further update at its next meeting.
	07.03.23	**Losses and Special Payments.** Committee members received a routine losses and special payments paper which highlighted that during the second and third quarters of 2022/23 there had been one loss reported, which related to a supplier whose emails had been hijacked by a scammer using a highly sophisticated system. The Committee was also informed that there had been no special payments recorded for the period. The Committee noted the update report
	07.03.23	**Management Responses - Informing the audit risk assessment.** Committee reviewed a report outlining responses from management to External Audit covering their assessment on a number of key areas: • General Enquiries of Management • Fraud, • Laws and Regulations, • Related Parties, • Going Concern, and • Accounting Estimates. The assessment provided by management contributes towards the information exchange between the ICB Management and the organisations External Auditors (Grant Thornton) and Audit Committee, The report covered important areas of the auditor risk assessment in compliance with audit standards and members were asked to consider the ICB approach. Members discussed fraud training and compliance rates. The Committee noted the report.

Decision Log Ref No.	Meeting Date	Issues considered
	07.03.23	**Internal Audit Progress Report, MIAA TIAN Insight Report & Draft 23/24 Internal Audit Plan.** The reports provided an update to the Audit Committee in respect of the assurances, key issues, and progress against the Internal Audit Plan for 2022/23. The Committee was advised that significant progress had been made in the following areas: • reports on Conflicts of Interest Core Controls Checklist, Key Financial Systems Core Controls Checklist, Quality Governance Core Controls Checklist had been completed • work on Payroll/ESR and Delegated Commissioning Assessments – Dental & Optometry had started. Internal Audit confirmed that for the Head of Internal Audit Opinion (HOIAO) would be considering the emerging assurance framework and risk management. Audit confirmed there was nothing fundamental that the ICB was missing and C&M ICB was not an outlier in terms of possible HOIA of Limited Assurance. The Committee also received an indicative draft Internal Audit plan for 2023-2024 for review and noted that it would receive the final draft for approval at its April 2023 meeting. The Committee noted the update reports.
	07.03.23	**Anti-Fraud Progress Update report** The report to Committee updated attendees on anti-fraud activities undertaken on behalf of the ICB in the current reporting period, in accordance with the Anti-Fraud Work Plan for 2022-23. Highlighted in the report were: • Counter fraud work undertaken with NHSE • ICB Risk assessment requirements and progress made • Proactive work on Conflicts of Interest • NFI matches had been released and a briefing would follow • Fraud mandate training started

Decision Log Ref No.	Meeting Date	Issues considered
		• Progress as detailed on the Delivery Dashboard & Contract Performance. The Committee noted the update report.
	07.03.23	**Supplier Set-Up Fraud & Anti-Fraud Interim Investigation Report.** The Committee received two reports – one from ICB management and one from the MIAA Anti-Fraud specialist regarding the recent bank mandate fraud committed in relation to changes to A supplier setup, and an update on investigation progress to date. Members were provided with the background to a fraudulent payment resulting from a sophisticated scam involving the hijacking of a supplier's email account. Initial findings from the investigation showed that controls that were in place were not adequately adhered to. Committee members were informed that the Police and an NHSCFA Financial Investigator were supporting the ICB in finding the money transfer trail and the ICB was relying on the former to arrest the criminals once found. In response to the fraudulent activity the ICB and anti -fraud colleagues from MIAA had: • issued specific communications to finance and wider teams • developed training with some sessions already taken place and others planned • firmed up the relevant mandate fraud guidance and supplier set-up and re-shared with key staff. • agreed that mandate checks would also be built this into future programmes of internal audit checks. • accounted for the payment as a loss in the ledger and included in the Losses and Special Payments Register. • Consideration about reducing number of staff who had approval responsibilities.
	07.03.23	**Bi-monthly IG Update Report.** Committee received its regular IG Update report which – due to the timing of the Committee and G

Decision Log Ref No.	Meeting Date	Issues considered
		Report distribution timelines – covered the period up until January 2023. Members were advised that the mandatory IG training compliance rate for ICB staff was 73% as at the beginning of March, and that work was ongoing to achieve the required 95% compliance rate. Members were informed that 15 IG breaches had occurred during the November – December 2022 period, with a trend analysis was being conducted to identify if there were any areas for concern. Board members heard that all place based Caldicott Champions had been trained by the IG Team, and that the Information Risk work programme had progressed with all place-based Deputy SIROs now trained, with the exception of Liverpool Place where the role was vacant. Training for Deputy SIROs, Asset Owners and Information Asset Administrators was also underway. The report to Committee also provided members with further information relating to: • the CSU management of change programme: • training analysis needs and confirmed that the CSU was working with the corporate teams • IG spot checks had started in Places • MIAA discussions • monthly IG meetings with the ICB corporate team. The Committee noted the report.
	07.03.23	**DSPT Baseline Submission Assurance.** Committee received a verbal update confirming that the DSPT submission was completed the week prior to the meeting. There were still many actions being progressed and the Committee received assurance from the IG team that there were no concerns regarding its successful completion as robust plans were in place. The Committee noted the update.

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
-	07.03.23	**ICB Declaration of Interest Update**. The Committee considered and **approved** minor changes to the ICBs Conflicts of Interest Policy.

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
-	-	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 Log Ref No.	Meeting Date	Recommendation from the Committee
-	-	None

6. Recommendations

6.1 **The Board is asked to:**

- **note** the items covered by the Audit Committee at its meeting on the 07 March 2023.

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NHS Cheshire and Merseyside Integrated Care Board Meeting

30 March 2023

Report of the System Primary Care Committee Chair

Agenda item	**ICB/03/30/19**
Report author & contact details	Christopher Leese c.leese@nhs.net
Report approved by (sponsoring Director/ Chair)	Clare Watson, Assistant Chief Executive
Responsible Officer to take actions forward	Christopher Leese c.leese@nhs.net

NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the System Primary Care Committee Chair

Executive Summary	The System Primary Care Committee of the NHS Cheshire and Merseyside Integrated Care Board met on 03 March 2023. The meeting was quorate and was able to undertake the business of the Committee. Declarations of interest where applicable where minuted.				
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.				

Key issues	The Committee discussed the following business as listed.
	In **Part A** , meeting held in private:
	
	• Community Pharmacy Update
	  • Minutes of PSRC (Pharmaceutical Services Regulatory Committee)
	  • Community Pharmacy Risk Register
	• Place Primary Care Forum Updates and Escalation Issues
	• Liverpool Place APMS Contract Award Issues
	• Outcome of Extra Ordinary Meeting held in January
	• Locally Commissioned Community Pharmacy Schemes and Minor Ailments Schemes
	• Budget Setting 23/24
	• Expression of Interest for Independent Prescribing in Community Pharmacy Pathfinder Programme
	
	In **Part B**, meeting held in public:
	
	• Presentations on the handover of Dentistry and GOS (General Ophthalmic Services) from NHS England
	• General Policy and Contracting Update including Primary Care risk register
	• Update on Operating Model and future Governance Arrangements for decision
	• Progress report - Development of A Primary Care Strategic Framework
	• General Finance Update
	• Place Update on Place Primary Care Spend and Impact
	• Update on System Pressures in Primary Care (General Practice)
	
	No questions before the meeting were asked by members of the public, for response				

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Key risks	Key risks were noted and mitigating actions confirmed as part of the main papers.			
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		X
Management of Conflicts of Interest	Managed by the Chair			
Next Steps	As detailed in the full papers			
Appendices	None			

Report of the System Primary Care Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
System Primary Care Committee	The role of the System Primary Care Committee shall be to oversee, coordinate and promote alignment of the functions amongst Places relating to the commissioning of primary medical services under section 82B of the NHS Act in relation to GP primary medical services and community pharmacy.	Erica Morriss

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
	2.3.2023	General community pharmacy update which included the: • minutes of the PSRC (Pharmaceutical Services Regulatory Committee). • Community pharmacy risk register noted for assurance The Committee received Place primary care forum updates and escalation issues, including representation from three places where there are significant challenges. Place leads action to provide options around potential mitigations at the next SPCC A decision regarding Liverpool place APMS Contract Award was delegated to a sub group of the SPCC to meet to make a decision outside of the meeting. Agreed minutes and decisions of the extra ordinary meeting held in January were noted in the formal minutes of the Committee. Issues and challenges in relation to budget setting for 23/24 were noted and discussed. Additional session to be arranged for all SPCC members to improve education of allocation nuances to enhance future detailed reviews.

Decision Log Ref No.	Meeting Date	Issues considered
		An Expression of Interest for Independent Prescribing in Community Pharmacy Pathfinder Programme was noted. Presentations on the handover of dentistry and GOS (General Ophthalmic Services) from NHS England were noted for assurance A general policy and contracting update including an update on the primary care risk register were noted for assurance A progress report on the development of a primary care strategic framework was noted for assurance A general finance update was noted for assurance A place update on newly awarded primary care spend including the impact on patients and outcomes so far was noted for assurance An update was given on current pressures in general practice which was noted for assurance.

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
	2.3.2023	Locally Commissioned Community Pharmacy Schemes and Minor Ailments Schemes. A decision was made to approve the current status subject to a detailed financial forecast being provided to SPCC and ICB Exec. An Update on the Primary Care Operating Model and governance arrangements post 1.4 for primary care were agreed

Decision Log Ref No.	Meeting Date	Issues considered
		A decision regarding an APMS contract escalated from Place was formally delegated to a small quorate group to make the decision ,outside of the committee. A decision was made by that group to proceed with the recommendation from place.

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
		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 Log Ref No.	Meeting Date	Recommendations
		None

6. Recommendations

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

- **Note** the contents of the report and the decisions therein.

NHS
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NHS Cheshire and Merseyside Integrated Care Board Meeting

30 March 2023

Report of the Finance, Investment & Resource Committee Chair

Agenda Item	**ICB/03/30/20**
Report author & contact details	Claire Wilson, Executive Director of Finance Claire.wilson@cheshireandmerseyside.nhs.uk
Report approved by (sponsoring Director/ Chair)	Erica Morriss, Chair of the Finance, Investment and Resource Committee
Responsible Officer(s) to take actions forward	Claire Wilson, Executive Director of Finance Mark Bakewell, Deputy Director of Finance

Cheshire and Merseyside ICB Board Meeting

Report of the Finance, Investment & Resource Committee Chair

Executive Summary	The Finance, Investment and Resource committee of the NHS Cheshire and Merseyside Integrated Care Board met on 21st February 2023 The meeting was quorate and was able to undertake its business. The main items considered at the meeting included: • Month 10 ICB / ICS Finance Report • 2023/24 Planning The committee also held a private meeting considering a number of procurement items relevant to the ICB Business and in accordance with the scheme of reservation and delegation The next meeting of the Committee is scheduled to be held on 28th March 2023.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X	X	X		
Recommendation	**The Board is asked to:** • **note** the items covered by the Committee • **note** that the committee considered the month 10 financial position of the ICB/ ICS in respect of both revenue and capital allocations • **note** that updates were received in respect of 2023/24 planning in respect of areas of finance, activity and performance.				
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				
Management of Conflicts of Interest	No				
Next Steps	None				
Appendices	None				

NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the Finance, Investment & Resource Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
Finance, Investment & Resource Committee	The main purpose of the Committee is to • provide the Board with a vehicle to receive the required assurances, review the management of associated risks, and understand further details as deemed appropriate for the committee to consider in relation to matters concerning, finance (both revenue and capital) , resources (e.g. workforce) and investment / dis-investment issues. • support the development and delivery of the ICS' financial strategy, oversee financial delivery and provide assurance on the arrangements in place for financial control and value for money across the system. • take a system view on use of resources and deployment but also provide a forum where ICB directors and ICB members can consider, govern and assure ICB actions as an employer.	Erica Morriss, 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 these issues required escalation to the ICB Board:

Decision Log Ref No.	Meeting Date	Issues considered
	21.02.23	**NHS Planning Guidance 23-24** **The Committee** • **Noted** the update received from lead officer regarding planning position in relation to finance, activity, performance and workforce. • **Noted** the continuing approach to the development of the Cheshire and Merseyside ICS strategic and operational planning requirements including the role of providers in developing a triangulated plan. • **Noted** that the tight submission dates for the operational plan and acknowledged the priority this

Decision Log Ref No.	Meeting Date	Issues considered
		would take with available Finance/Performance & Workforce corporate resource over the next 6 weeks until submission.

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
	21.02.23 (Private)	The private section of the meeting considered a number of procurement items relevant to ICB Business and was in accordance with the scheme of reservation and delegation

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
-	21.02.23	**Month 10 Finance Report** The Committee noted • the contents of the finance report in respect of the month 10 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year. • The relative level of risk in delivering the forecast outturn position

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:

- **Note** the main areas of discussion at the committee meeting which were in line with workplan
- **Note** the financial position risks as described within the Month 10 Finance Report.

7. Next Steps

7.1 The committee will

- continue to meet monthly at the present time in order to provide assurances to the board as per its terms of reference and agreed workplan
- continue to monitor the financial position and associated risks both as the ICB but also as part of the ICS in order to deliver the required financial position.

NHS Cheshire and Merseyside Integrated Care Board Meeting

30 March 2023

Report of the Transformation Committee Chair

Agenda Item No	**ICB/03/30/21**
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

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: • The transformation governance and reporting process and an update on the progress of all the Cheshire and Merseyside Transformation Programme delivery vehicles • Reports on Maternity Treating Tobacco Dependence and Reducing Smoking Prevalence • An update on transformation programmes and future planning • Updates on other key programmes within the remit of the committee, including Specialised Commissioning, Major Change, NHSE and Digital Transformation and Clinical Improvement.

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 and the next steps.
Key issues	• Capacity constraints in Business Intelligence Team has led to limitations with support for some transformation programmes. Mitigating plans to streamline reporting of processes will address this and further engagement to take place on determining BI priorities from the transformation programmes • The 2023 – 2024 funding for the Treating Tobacco Dependency Programme. • A working group will look to at the effectiveness and efficiencies of the transformation work programmes to inform the future investment profile
Key risks	• Failure to identify our priorities will lead to a lack of focus and capacity on areas sufficiently to make adequate progress.

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		

Management of Conflicts of Interest	Not applicable
Next Steps	The Transformation Committee has asked for further reports to be presented to their next committee in relation to: • The outcomes of the working group that is being established to review the effectiveness and efficiencies of the transformation work

Cheshire and Merseyside ICB
Board Meeting

	programmes and inform the investment in 2023-24. • The C&M VCFSE Transformation programme which details the total ICB funding, including from Places, currently invest in the VCFSE sector. • The Teledermatology Service, detailing a revised funding proposal in line with the wider transformation programmes. • Confirmation of Treating Tobacco Dependency Programme funding for 2023-24.
Appendices	N/A

Cheshire and Merseyside ICB
Board Meeting

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 HCP 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

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
	09/03/23	The Transformation Programme Assurance Report outlined the refreshed governance arrangements for the ICB transformation programme activity and the status of the delivery vehicles, including whether metrics are in place or not. A delay to the Cardiac Network programme relating to CIPHA was reported and is due to the historic risk around the uncertainty of the future of CIPHA. There is a proposal to continue funding for this whole platform which requires financial approval from FiR. The lack of BI support for the Respiratory Programme was raised due to the high volume of requests received. Work is ongoing around the standardisation of the metrics and standard reports to help with BI capacity moving forward. Further engagement with the BI team is planned as part of the ongoing planning process.
	09/03/23	An update on Treating Tobacco Dependency was provided to the committee, detailing the roll-out of Maternity TTD sites, including funding. There is no confirmation as yet of funding for 23/24 and this remains a challenge. Trusts have still been attempting to mobilise without this assurance and there will be continued close working with trusts and maternity sites using existing local relationships already in place, offering support where needed from a Place perspective. Clarification on 2023-2024 Treating Tobacco Dependency funding is yet to be provided from the NHSE regional team.

	09/03/23	A paper was presented on behalf of CHaMPS outlining the need to do a rapid scoping review around the future of smoking cessation across C&M with a number of key policy drivers. Funding from the Treating Tobacco Dependency programme is available for this for which NHSE regional team are supportive. The committee endorsed the proposals in the paper, and the allocation of £50,000 to CHaMPs to mobilise this work.
	09/03/23	The Committee considered a report that gave an update on the transformation programmes and future planning, including the alignment of the planning guidance and programme mapping as well as the funding considerations for the transformation programmes in 23/24. Programmes were asked to submit details of the minimum amount of funding required for Q1 and for what purpose. The next steps for Q1 and Q2 funding was discussed, acknowledging the need for robust visibility on the funding and slippage, and the sequential activity that will need to be undertaken following Q1, including presenting the draft Joint Forward Plan by the end of the month and the need to develop a timeline to work through for the detailed plans and identify resource needs and sourcing. The Committee agreed to Q2 funding for each of the programmes, with a view that the same proportion or percentage of efficiencies are applied. A working group is to be established to review the effectiveness and efficiency opportunities of the transformation programmes, looking at what is planned to be delivered, in line with planning guidance, prioritisation framework and Marmot Core20 PLUS5. An update will be brought back to May's meeting.
	09/03/23	A presentation was delivered which outlined the plan for year one of the three-year C&M VCFSE Transformation programme. This outlined some of the outcomes delivered to date, including integrated VCFSE in system governance and workstreams on the development of place based VCFSE delivery models and also the key priorities being looked at for 23/24. The Committee was interested in understanding the total funding places currently invest in the voluntary

		sector, alongside the centrally agreed funding, and the need to look at best value, synergies, opportunities etc. for joint commissioning and where funding can be used better and a report back to the committee will be provided on this.
	09/03/23	The Committee received a report regarding the implementation of the Teledermatology service and the current financial pressure to this programme. There are significant pressures to the dermatology service, including the increased rate of two-week wide cancer referrals. A pilot that commenced in 2019 with four South Liverpool practices resulted in a high percentage of appointments being returned to advice and guidance with no appointments with secondary care. Programme funding of £300k is required for 2023-2024, the risks associated to this programme not being funded is a significantly high number of referrals to secondary care and many patients triaged with likely skin cancer will not be seen as quickly. The Committee supported the proposal for Q 1 but recommended further investigation into how this would be funded. Discussions ongoing with DoF as part of the 23/24 planning round.
	09.03.23	Further updates were provided on other key programmes <u>Specialised Commissioning</u> The ICB will not be taking on any specialised services commissioning functions until April 2024 and a shadow year will be put in place. A joint working document with the other two system in the NW and also Region will need to be signed off for March's ICB Board. Joint committees will need to be established. The report outlined the time plan for key activities and all updates will come back to the Committee moving forward. <u>Major Change</u> An overview of some of the ongoing work was presented with plans for a number of them still being developed/refreshed for 23/24. <u>NHSE/I</u> Pharmacy, ophthalmology, and dental teams are being consulted with and it is anticipated they will join the ICB from the April to support delegated functions. Other functions will transfer to the ICB in

		two tranches (July 23 and April 24) but clarity on which functions is unknown and resource will need to be reviewed for potential efficiencies. <u>Digital Transformation and Clinical Improvement</u> A report summarised the position around the governance across digital transformation and clinical improvement to provide assurance and get a robust view across a number of programmes within this area, with further discussions to be held to ensure the right representation is in place and utilising opportunities across the programmes of work. Fuel Poverty was discussed and may fall under the Population Health Board moving forward.

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
		N/A

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
		N/A

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	Issue for escalation	Recommendation from the Committee
			N/A

6. Recommendations

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

- Note the contents of this report

7. Next Steps

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

- The outcomes of the working group to be established to review the effectiveness and efficiencies of the transformation work programmes.
- The C&M VCFSE Transformation programme which details the total funding places currently invest in the voluntary sector.
- A revised funding proposal is submitted for maintaining progress in the Teledermatology Service implementation.