NHS
Cheshire and Merseyside

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

30 July 2026
13:00pm

The Conference Suite,
Riverside Innovation Centre,
1 Castle Drive, Chester,
CH1 1SL

Compassionate Inclusive Working Together Accountable

Leading integration through collaboration

Public Notice:

Meetings of the Board of NHS Cheshire and Merseyside are business meetings which for transparency are held in public.

They are not 'public meetings' for consulting with the public, which means that members of the public who attend the meeting cannot take part in the formal meetings proceedings. Members of the public are welcome to attend and observe the meeting.

The Board of NHS Cheshire and Merseyside holds its meetings in public (but these are not public meetings). As such we do our utmost to ensure that these meetings take place in publicly accessible locations and buildings across Cheshire and Merseyside.

All Board meetings held in public are live-streamed via **our YouTube channel** to enable those who are unable to attend in person to observe the meeting, with recordings of these meetings also made accessible via our **Meeting and Event Archive**.

Raising Questions:

Members of the public are able to submit questions to the Board via email. Questions should be sent to **Board@cheshireandmerseyside.nhs.uk** at least three working days prior to the Board meeting.

Questions from members of the public will be responded to at the beginning of the meeting by the relevant member of or attendee to the Board.

This will be subject to the question(s) raised and whether a substantial response can be provided at the meeting itself.

Questions raised that relate to specific items on the Agenda of the meeting of the Board in question will be prioritised for response on the day of the meeting of the Board.

Additionally, these questions will be responded to by the Board in writing (within 20 working days following the date of the meeting where possible) to the individual(s) who submitted the question(s) and will also published on the ICB website.

Further details can be found at:
https://www.cheshireandmerseyside.nhs.uk/get-involved/upcoming-meetings-and-events/nhs-cheshire-and-merseyside-integrated-care-board-may-2026/

Agenda

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
13:00pm	**Preliminary Business**				
ICB/07/30/26/01	Welcome, Apologies and confirmation of quoracy	Verbal	**Sir David Henshaw** *ICB Chair*	For information	-
ICB/07/30/26/02	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 on the ICB website)*	Verbal		For assurance	-
ICB/07/30/26/03	Minutes of the previous meeting: • 28 May 2026	Paper		For approval	Page 5
ICB/07/30/26/04	Board Action Log	Paper		For approval	Page 20
ICB/07/30/26/05	Key issues – significant items to raise	Verbal		For discussion	-
ICB/07/30/26/06	Chairs announcements	Verbal		For information	-
ICB/07/30/26/07	Questions received from members of the public	Verbal		For information	-
ICB/07/30/26/08	Experience / achievement story	Film		For information	-
13:30pm	**ICB Business Items**				
ICB/07/30/26/09	Reflecting on Government commissioned reviews – Ockenden (Nottingham) and Amos Maternity Reviews	Paper	**Kerry Lloyd** *Chief Nursing Officer*	For information	Page 21
ICB/07/30/26/10 **13.50pm**	Cheshire and Merseyside Provider Collaborative (CMPC) Annual Work Plan for 2026	Paper	**Janelle Holmes** *Chief Executive WUTH & WCHC*	For endorsement	Page 40
ICB/07/30/26/11 **14.10pm**	Board Assurance Framework (BAF)	Paper	**Ben Vinter** *Executive Corporate Services & Governance*	For assurance	Page 68
ICB/07/30/25/12 **14.25pm**	Primary Care / NHS Business Case	Paper	**Clare Watson** *Executive Director of Health & Integrated Care Commissioning*	To information	Page 85
14.35pm	**Break**				
14:55pm	**Leadership Reports**				

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
ICB/07/30/26/13	Report of the ICB Chief Executive	Paper	**Liz Bishop** *Chief Executive*	For assurance	Page 92
ICB/07/30/26/14 **15:10pm**	Cheshire and Merseyside ICB and System Finance Report – Month 3	Paper	**Andrea McGee** *Executive Director of Finance and Contracting*	For assurance	Page 108
ICB/07/30/26/15 **15:20pm**	Highlight report of the Chair of ICB Finance, Investment and Contracting Committee	Paper	**Sue Lorimer** *Non-Executive Member*	For assurance	Page 115
ICB/07/30/26/16 **15:25pm**	NHS Cheshire and Merseyside Integrated Performance Report	Paper	**Jude Adams** *Interim Executive Director of Transformation & Strategy (Turnaround)*	For assurance	Page 123
ICB/07/30/26/17 **15:45pm**	Highlight report of the Chair of ICB Quality and Performance Committee	Paper	**Tony Foy** *Non-Executive Member*	For assurance	Page 168
ICB/07/30/26/18 **15:50pm**	Highlight report of the Chair of the Audit Committee	Paper	**Mike Burrows** *Non-Executive Member*	For assurance	Page 173
ICB/07/30/26/19 **15:55pm**	Highlight report of the Chair of System Primary Care Committee	Paper	**Tony Foy** *Non-Executive Member*	For assurance	Page 176
ICB/07/30/26/20 **16:00pm**	Highlight report of the Chair of Northwest Specialised Commissioning Committee	Paper	**Dr Ruth Hussey** *Non-Executive Member*	For assurance	Page 181
16:05pm	**Closing Business**				
ICB/07/30/26/21	Closing remarks and review/reflections of the meeting	Verbal	**Sir David Henshaw** *ICB Chair*	For information	-
ICB/07/30/26/22	Any Other Business	Verbal		For information	-
16:10pm CLOSE OF MEETING					

Date and start time of future meetings

- **24 September 2026.13.00pm – The Village Hotel, 110 Centre Park Square, Warrington, WA1 1QA**

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

NHS
Cheshire and Merseyside

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

Thursday 28th May 2026, 1:00pm – 4:30pm

Held in The Holiday Inn, Lime Street, Liverpool, L1 1NQ

Draft Minutes

ATTENDANCE	
Name	**Role**
Members	
Sir David Henshaw	Chair, Cheshire & Merseyside ICB (voting member)
Liz Bishop	Chief Executive, Cheshire & Merseyside ICB (voting member)
Tony Foy	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Dr Ruth Hussey, CB, OBE, DL	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Prof Hilary Garratt, CBE	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Warren Escalade	Partner Member (VCFSE) (Voting Member)
Adam Irvine	Partner Member (Primary Care), Cheshire & Merseyside ICB, (voting member)
Dr Fiona Lemmens	Executive Clinical Director, Cheshire & Merseyside ICB (voting member)
Clare Watson	Executive Director of Health and Integrated Care Commissioning, Cheshire & Merseyside ICB (voting member)
Sue Lorrimer	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Mike Burrows	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Trish Bennett	Partner Member (NHS Trust), Cheshire & Merseyside ICB (voting member)
Andrew Lewis	Partner Member, (Local Authority) (Voting Member)
Andrea McGee	Executive Director of Finance and Contracting, Cheshire and Merseyside ICB (voting member)
Ben Vinter	Executive Director of Corporate Services and Governance, Cheshire and Merseyside ICB (voting member)
In Attendance	
Jude Adams	Interim Executive Director of Strategy and Transformation, Cheshire and Merseyside ICB
Louise Robson	Chair, Health Innovation North West Coast (regular participant)
Jennie Williams	Senior Executive Assistant (Note Taker), Cheshire and Merseyside ICB

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John Llwelleyn	Chief Digital and Information Officer, NHS Cheshire and Merseyside
Temitayo Roberts	Freedom to Speak up Guardian, NHS Cheshire and Merseyside
Kaite Horan	Programme Manager Staff Experience and Retention
Apologies	
Name	**Role**
Prof. Ian Ashworth	Director of Population Health, Cheshire & Merseyside ICB (regular participant)
Delyth Curtis	Partner member (Local Authority) (voting member)
Erica Morriss	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Prof. Paul Kingston	Chair of ICB Research and Innovation Committee, (regular participant)
Dr Naomi Rankin	Partner Member (Primary Care) (voting member)

Agenda Item, Discussion, Outcomes and Action Points
Preliminary Business
ICB/05/26/01 Welcome, Apologies and Confirmation of Quoracy
The Chair welcomed the Board to the NHS Cheshire and Merseyside ICB Board meeting in public, apologies were noted, and it was confirmed that the Board was quorate. The Board received a petition from members of Save Liverpool Women's Hospital regarding the closure of Liverpool Women's Hospitals.
ICB/05/26/02 Declarations of Interest
None.
ICB/05/26/03 Minutes of the previous meeting of 26th March 2026
The minutes of the previous meeting held on 26th March 2026 were accepted and recorded as a true and accurate reflection of the meeting.
ICB/05/26/04 Board Action Log
The Board agreed the actions as listed.
ICB/05/26/05 Key Issues – Significant Issues to Raise
There were no key issues raised by Board members.
ICB/05/26/06 Chairs Announcements
None.
ICB/05/26/07 Questions Received from Members of the Public
The Board discussed questions received from members of the public; full responses will be available on the ICB website from 30th May 2026 - may-2026-icb-board-questions-and-

Agenda Item, Discussion, Outcomes and Action Points
responses-final.pdf The Board noted receipt of a petition from a campaign group in relation to women's services in the city.
ICB/05/26/08 Experience / Achievement Story
The Board received an update from Clare Watson (CW) on the next phase of the Cheshire and Merseyside Altogether Smokefree programme, led by CHAMPS, with the launch of the new Smoking Ends Here campaign, Stop for Good. The campaign is a population level, insight led initiative across Cheshire and Merseyside, using a multi-channel communications approach to direct residents to local smoking cessation support via the Smoking Ends Here website. The campaign focuses on the wider emotional and family impact of smoking, aims to encourage quit attempts, and emphasises that quitting smoking is often a long-term journey requiring sustained support. Campaign materials feature local residents and real-life case studies. It was reported that the Smoking Ends Here website has attracted over 100,000 unique visitors to date, with campaign activity generating more than 50 million impressions across all channels. **The Board welcomed the campaign and accompanying video.**
ICB Business Items
ICB/05/26/09 Proposed changes to complex and high-risk maternity and gynaecology care in Liverpool – a public engagement approach
The Board received a paper from FL setting out the proposed public engagement approach in relation to the medium-term service development proposal for complex and high-risk maternity and gynaecology care in Liverpool, previously agreed in principle by the Board in January 2026. The proposal relates to a relatively small cohort of patients, affecting approximately 30 maternity patients and up to 100 gynaecology patients each year. The Board was asked to review the proposed engagement approach and approve the commencement of a six-week public engagement period from 2nd June to 14th July 2026. Members noted the legal and statutory context for public involvement and that, whilst the scale of service impact might not ordinarily require a broad engagement exercise, the significant level of public interest in women's services in Liverpool supported a more extensive approach, in line with legal advice received. It was noted that feedback would be gathered primarily through an online questionnaire, supported by paper and telephone options, targeted interviews and one-to-one conversations with service users, and three public in-person information events. The continued involvement of the lived experience panel in shaping the engagement approach was noted. Members were advised that the proposed plan reflects learning from previous engagement activity. FL responded to a question from the member of the public explaining that the proposed changes are intended to address recognised concerns regarding the current model of maternity care in the

city, particularly the challenges associated with managing unpredictable clinical circumstances safely and consistently for women and babies. It was emphasised that the proposal is driven by the need to ensure care is delivered in line with clinical expectations and standards. For women with a planned caesarean birth at the Royal Liverpool University Hospital, detailed individualised care plans would be agreed in advance between the woman, her obstetrician and midwife. These plans would include clear arrangements for managing any complications or the onset of labour prior to the planned date, ensuring women understand exactly what action to take in such circumstances.

The Board -

- **Considered the proposed approach to holding a public engagement on proposed changes to where high risk and complex gynaecology and maternity care takes place in Liverpool, presented in the paper.**
- **Reviewed the formal communication and engagement plan.**
- **Provided approval to progress with the launch the proposed six week public engagement period, running from 2 June – 14 July 2026, based on these plans.**

ICB/05/26/10 Governing the NHS Cheshire and Merseyside Single Improvement Plan - Terms of Reference for ICB Task and Finish Committee

The Board considered a proposal from Ben Vinter (BV) to establish a Board level Task and Finish Group to provide oversight and governance for delivery of the Single Improvement Plan Improvement and Development Oversight Committee IIDOC)). At the March 2026 meeting, the Board received a briefing on the scope and proposed approach to the Single Improvement Plan and had supported the development of appropriate governance arrangements. It was proposed that, from June 2026 a Board level Task and Finish Group be established, chaired by the Board Chair and comprising a number of Non-Executive Directors, to support and oversee executive-led delivery of the Plan.

The Board

- **Agreed the ToR to establish and IDOC and enact this assurance structure from June 2026**
- **Noted that the majority of the business considered by the committee will be on an exception and headline basis with a significant amount of action assurance being conducted by SIPG.**

ICB/05/26/11 Cheshire and Merseyside Cyber Security Improvement Programme Update

The Board received an annual update on the system-wide cyber resilience programme from John Llewellyn (JL). Over the previous 12 months, progress has been made despite the programme initially operating on a best endeavours basis in the absence of confirmed national funding. It was reported that the programme is now formally funded and has been recognised as a national digital priority for the next four years.

The programme has been reset, with strengthened leadership arrangements in place, including

dedicated senior responsible officer oversight and ring-fenced leadership capacity to support delivery. The overarching principle for the programme is to "defend as one", reflecting the increasing system-level cyber risk associated with shared pathways, cross-organisational information flows, and workforce movement across organisational boundaries.

The focus for the first year of the reset programme is the development of a common approach to governance, assurance, standards and metrics across partner organisations, enabling a consistent assessment of risk and more targeted deployment of improvement support. Arrangements are being established for a system-wide incident response capability to provide co-ordinated expertise in the event of a cyber incident.

A regional three-day EPRR exercise focused on a major cyber incident is planned for July 2026 to test system preparedness. Future phases of the programme will include further investment in shared systems and surveillance, with the immediate priority being to strengthen collective understanding of system vulnerabilities, risk exposure and mitigation.

The Board -

- **Noted the current cyber risk context for healthcare organisations nationally and across Cheshire and Merseyside.**
- **Noted the refresh of the Cheshire and Merseyside Cyber Programme and its alignment with wider system design, assurance and governance arrangements.**
- **Endorsed the principle that assurance should reflect cross-organisational pathways, suppliers and shared platforms, as well as individual organisational risks.**
- **Supported the development of a consistent provider-level oversight route and reporting cadence for cyber assurance.**
- **Noted the proposed use of provider subject matter expertise to support system resilience, future planning and support of the planned national/regional cyber incident simulation in July 2026.**
- **Supported the development of a consistent baseline of cyber understanding across trust boards and executive leaders.**

ICB/05/26/12 NHS Cheshire & Merseyside Antimicrobial Resistance and Infection Prevention & Control Update

The Board received a report setting out the ICB's response to the national requirements in relation to antimicrobial resistance (AMR) from FL. Expectations set out by NHS England include the requirement for Board-level oversight and executive leadership of AMR performance, completion of a self-assessment and Board assurance framework, and agreement of three local priorities for improvement.

Overall antibiotic prescribing rates are reducing and that Cheshire and Merseyside is performing strongly in relation to the proportion of antibiotic courses prescribed for five days or less, in line with current evidence-based practice. However, members also noted that rates of broad-spectrum antibiotic prescribing remain high and that in-hospital intravenous antibiotic prescribing continues to require improvement.

Agenda Item, Discussion, Outcomes and Action Points

The current self-assessment demonstrates partial compliance with national requirements. The Antimicrobial Stewardship Group, led by the Medicines Optimisation team will continue to develop the assurance framework and report progress through the Quality and Performance Committee.

The Board noted the three priority areas identified for improvement, reducing antibiotic prescribing in children aged 0–9 years, increasing the proportion of antibiotic courses of five days or less, and supporting the systematic review and removal of inaccurate penicillin allergy records in order to reduce unnecessary use of broad-spectrum antibiotics.

The Board Discussed -

- The clarity of the proposed actions and the importance of maintaining focus on antimicrobial resistance alongside other operational pressures. Clarification was sought regarding the scale of the population recorded as having a penicillin allergy and the extent to which primary care prescribing data included prescribers operating through services such as Pharmacy First, in addition to general practice. In response, FL advised that confirmation would be provided on the proportion of patients recorded as having a penicillin allergy. It was noted that the prescribing data is understood to relate primarily to GP prescribing, reflecting the availability and quality of current data; however, further clarification would be sought regarding the inclusion of prescribing undertaken by community pharmacists.
- The importance of ensuring that clear and accessible patient-facing information is developed to support any review and removal of inaccurate penicillin allergy records. It was noted that, where a penicillin allergy label is removed from a patient record, consistent communication and explanation will be required to support patient understanding and confidence. Patient materials should clearly explain the rationale for de-labelling, including the clinical benefits of enabling access to the most appropriate antibiotic treatment and reducing the potential harms associated with the unnecessary use of broader-spectrum alternatives.
- Through Health Innovation North West Coast, Cheshire and Merseyside is working with the Fleming Initiative to support the development of new diagnostics aimed at improving the accuracy of antibiotic prescribing. The system is also leading real-world testing of these innovations within acute hospital settings. This work has important implications for future strategic commissioning and the adoption of evidence-based diagnostics in practice, positioning Cheshire and Merseyside at the forefront of this area of development.
- Progress made in reducing total antibiotic prescribing in primary care over recent years the recent plateau in performance indicated that the system had reached the limits of achievable improvement. Further improvement remains possible, although this is likely to become increasingly challenging as the more readily achievable opportunities have already been addressed.

Action

FL to gather information on the numbers involved in the penicillin de-labelling programme and the percentage of people who are affected; and data for primary care prescribing rates, is this just GP's or is other prescribers.

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Agenda Item, Discussion, Outcomes and Action Points

The Board:

- **Noted the requirements of the NHS England Act now: protect our present, secure our future letter (Appendix One) and the current AMR/IPC reporting mechanism across NHS Cheshire and Merseyside.**
- **Endorsed the three priority areas for AMR improvement within NHS Cheshire and Merseyside.**

ICB/05/26/13 NHS Cheshire and Merseyside Freedom to Speak Up Annual Report

The Board received the annual Freedom to Speak Up (FTSU) update from Temitayo Roberts (TR) and BV, noting that this is supported by regular reporting to the Audit Committee during the year. The report summarises key developments at both national and local level, including the transition of responsibilities following the closure of the National Guardian's Office and the evolving relationship with NHS England in this area.

Findings of the recent FTSU survey indicated high levels of awareness of the service, highlighting that some colleagues do not yet feel fully confident in using it due to concerns about in-action or reprisal. The importance of continuing to strengthen the FTSU approach as part of the wider cultural development of the ICB and implementation of the new operating model was recognised.

TR emphasised the importance of continued Board endorsement and support in order to further strengthen Freedom to Speak Up arrangements within the ICB. The forthcoming closure of the National Guardian's Office at the end of June 2026 and the transfer of its functions to NHS England was noted. Continued oversight and support will be required in relation to Freedom to Speak Up arrangements across primary care, including dentistry, optometry, community pharmacy and general practice, particularly in the context of ongoing national uncertainty regarding future responsibilities and arrangements.

The Board –

- **Noted the development of national risk assessment checklist of the detriment guidance and approve its adoption within Cheshire and Merseyside.**
- **Re-affirmed Board support for senior leaders' awareness and completion of FTSU processes within the ICB, and FTSU E-learning module 3 – 'Follow up with action' and familiarise with the information on the FTSU staff hub Freedom to Speak Up and actively engage with promoting speaking up within the ICB.**
- **Supported the integration and promotion of a strong FTSU culture into future leadership training and cultural programmes.**
- **Supported the development and implementation of the action plan that results from the ICB FTSU survey completed during March 2026, supporting implementation of the ICB operating model and integration of teams.**
- **Noted the progress made with the ICB FTSU arrangements within the ICB and ICS and noted the continuing need to support and embed FTSU approaches with partners in primary care (Appendix Three and Four).**

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ICB/05/26/14 NHS Cheshire and Merseyside NHS Staff Survey Results 2025-26 and next steps

The Board received an update on the ICB staff survey results from Katie Horan (KH). This year's report relates solely to ICB staff and no longer includes wider ICS or system results, which are now the responsibility of NHS England. For the first time, completion of the GP staff survey will be mandated through the national contract, with the ICB People Team providing support to practices as further details emerge.

The overall response rate has reduced from 73% to 58% and whilst this remained a comparatively strong response rate, members were advised that there had been a decline across all People Promise themes, by an average of 0.6 points, resulting in the ICB's performance falling below the national average for ICB's. The weakest scoring themes were reported as "We are always learning", "We have a voice that counts", and "Safe and healthy".

Equality and diversity remained a particular strength, alongside positive results in relation to line management and flexible working. The three main areas of focus for improvement would be understanding work pressures and supporting staff wellbeing, strengthening confidence that speaking up leads to visible action, and improving the learning, development and appraisal experience. These priorities will be supported through ongoing organisational change work, continued wellbeing activity, staff engagement sessions, alignment with Freedom to Speak Up actions, and the introduction of a revised appraisal process linked to organisational values, strategic objectives, health and wellbeing, and professional development. The learning and development offer would be refreshed and more clearly promoted to staff.

The Board Discussed -

- Seeking assurance that more regular mechanisms would be in place to monitor staff experience between annual staff surveys, particularly in the context of ongoing organisational change. In response, the Board was advised that quarterly national pulse surveys have now commenced, with the first results recently received, although response rates are currently relatively low. The People Team is undertaking additional engagement activity through regular team visits and a monthly staff engagement forum to gather feedback and support improvements in staff morale and engagement.
- The importance of taking both an individual and organisational approach to learning and development, noting that appraisal processes should support personal development needs while also informing a broader assessment of the skills and capabilities required by the ICB as a strategic commissioning organisation. In response, the Board was advised that a skills development questionnaire has been piloted to complement the appraisal process and align workforce development to the strategic commissioning framework and organisational priorities. Early findings have identified needs in areas including data analysis, translating data into action, and commissioning skills, and that this would be supported through both local development work and opportunities available through the Commissioning Academy. The importance of strengthening core organisational capabilities, including financial and digital literacy, across the wider workforce and senior leadership team was emphasised.
- The value of focusing on core organisational fundamentals, including psychological safety and basic capability development, as a foundation for improving staff experience. National finance

accreditation frameworks demonstrate a clear correlation between stronger organisational capability and improved staff survey outcomes.

- The forthcoming launch of the National Strategic Commissioning Development Programme and the range of development opportunities it is expected to provide, including support through the Commissioning Academy, leadership and professional development, commissioning intelligence, and action learning. The ICB is participating in preparatory work ahead of the national launch, including a pilot of the self-assessment approach, and that the programme is intended to support strategic commissioning capability across the wider organisation rather than within commissioning teams alone. The opportunity for participation in national action learning on neighbourhood health and the importance of aligning national offers with local leadership and organisational development activity was noted.
- An apparent inconsistency between the positive line management scores and weaker results in areas such as workload, support and staff experience. It was emphasised that these issues should be addressed through effective line management, including objective setting, regular one-to-one discussions and ensuring staff have the tools and support required to undertake their roles. The need to maintain a clear focus on strengthening line management capability as part of the ongoing organisational restructure and not to be complacent in light of the positive overall line management score was noted.

The Board -

- **Noted the ICB staff survey results, including the themes from the free text feedback.**
- **Endorsed the proposed organisational priorities and the approach to delivery and assurance.**
- **Supported a continued "you said, we did" approach so staff can see what has been done, what has not been done, and why.**

ICB/05/26/15 Delegation of Specialised Services Update

The Board received an update on the delegation of specialised services from CW, noting that this was the first formal report to Board since Cheshire and Merseyside ICB assumed delegated responsibility in April 2024. The portfolio comprises of an allocation of £849 million and includes a broad range of highly specialised services provided to relatively small patient cohorts.

The update provided assurance on the scope of delegated services, the associated financial and governance arrangements, and the opportunities to take a more strategic and integrated approach to commissioning specialised pathways, including greater focus on prevention and earlier intervention. The alignment between specialised commissioning priorities and the ICB's Population Health Improvement Plan was noted.

Of approximately 150 specialised services, 70 have now been delegated to ICB's, representing the majority of the budget, with the most highly specialised services remaining commissioned at regional or supra-regional level. Governance is provided through the North West Joint Committee for jointly commissioned services and through the ICB's Specialised Commissioning Oversight Group for those services commissioned directly by the ICB, with reporting through to the Executive Committee and quality oversight provided via the Quality and Performance Committee.

NHS England currently continues to provide operational support to these arrangements, working

closely with the ICB, and that opportunities for increased local oversight and integration are being developed as governance arrangements evolve. An internal audit undertaken by MIAA across the three North West ICB's had provided substantial assurance in relation to delegated specialised commissioning arrangements.

Andrea McGee (AM) advised that closer working between the ICB and specialised commissioning had strengthened during 2025/26 and would be further developed in 2026/27. This includes revised Finance Committee terms of reference to provide for specialised commissioning representation and regular reporting. The ICB is working with specialised commissioning to develop a more streamlined and integrated approach to provider contract oversight, with the aim of reducing duplication and enabling a more coordinated discussion with providers across the whole commissioning landscape, this single approach would continue to be refined during the year.

A North West population health inequalities and prevention strategy is in place and the ICB has advocated for future development of this work as an integrated population health plan with ICB's, reflecting the close alignment with local strategic priorities and the Population Health Improvement Plan. The specialised commissioning priorities for 2026/27 are aligned to the ICB's wider strategic ambitions and objectives for the year.

The renal transformation programme is a strong example of a "left shift" approach within specialised commissioning. The programme has extended the focus of specialist renal services upstream within the pathway, supporting earlier identification and intervention for patients with deteriorating kidney function through a pilot involving seven GP practices in Liverpool. It was reported that early outcomes from the pilot are encouraging, with the expectation that this will contribute over time to a reduction in progression to advanced kidney disease and the need for dialysis.

CW advised that the report was presented to provide assurance that specialised commissioning forms an important part of the ICB's responsibilities and that, given the scale of the delegated budget and the opportunities for more strategic end-to-end pathway commissioning, further reports would be brought to Board in future. Assurance in relation to the wider North West delegated specialised commissioning arrangements would continue to be provided through the Joint Committee and associated assurance reporting.

The Board Discussed –

- The scale of delegated specialised commissioning, emphasising the need for continued Board scrutiny. The importance of integrating prevention, equity and end-to-end pathway planning was highlighted, alongside the need to ensure equitable access to specialised services across the ICB footprint.
- The need for greater clarity on investment prioritisation, more measurable objectives for 2026/27, and a clear approach to scaling successful pilot initiatives, such as the renal transformation programme. Regular assurance reporting from the North West Joint Committee should be brought to Board to support transparency and accountability.
- An emerging risk, identified through OPIC discussions, in relation to the future of clinical networks. It was highlighted that a number of key specialised commissioning priorities,

including thrombectomy optimisation and renal transformation, are currently led through these networks.

Members reflected on the evolving role of ICB's and noted that, whilst some functions had originally been expected to transfer elsewhere, there is currently limited evidence of this in practice. It was noted that no significant functions have yet been removed, and that areas previously expected to transfer, including safeguarding and SEND, have remained within ICB responsibilities.

In closing, members noted the intention to further integrate specialised commissioning within the ICB's commissioning arrangements, with strengthened leadership oversight and closer working with North West colleagues. The importance of maintaining a population-based approach to commissioning was emphasised, with particular regard to equity of access and maximising the strategic opportunities presented by delegated specialised commissioning.

The scale of investment involved and the importance of ensuring that associated financial and delivery risks are appropriately identified and managed through existing governance arrangements was highlighted, including the Finance Committee.

The Board Noted –

- **The range, context, financial information and governance arrangements which supports the delegation of specialised services by NHS England to the ICB.**
- **The priority areas of focus within our 2026-31 Population Health Improvement Plan related to delegated specialised services and the anticipated strategic improvements we are aiming to achieve.**

Leadership Reports

ICB/05/26/16 Report of the ICB Chief Executive

The Board received the Chief Executive's report from LB, the updated operating model was published at the end of April 2026, setting out the organisation's vision, objectives and operating arrangements. Progress in relation to the management of change programme was noted and thanks were recorded to colleagues who had recently left the organisation through the voluntary redundancy scheme.

As part of the Single Improvement Plan and wider governance development, the Executive Committee will be strengthened and re-focused to provide delegated oversight of day to day ICB delivery and decision making, with reporting through to the Board.

The recent multi-agency response to the hantavirus incident and the repatriation of individuals to Arrowe Park Hospital was noted, and thanks were recorded to colleagues at Wirral University Teaching Hospital for the effective and timely coordination of this work.

Waiting times across Cheshire and Merseyside continue to improve, with the system now ranked 14th nationally, reflecting the collaborative efforts of acute providers working through the Provider Collaborative.

The launch of Health Innovation North West's new strategy focused on supporting the adoption of proven innovations to improve health and wellbeing, and was received for information a summary of matters considered and agreed by the Executive Committee.

The Board discussed the strengthening of the ADHD webpage forms part of a broader and more comprehensive programme of work in relation to ADHD commissioning. It was reported that a recent detailed discussion at the Finance Committee had provided increased assurance regarding the scope and strength of the overall programme.

The Board -

- **Considered the updates to Board and sought further clarification and detail.**
- **Will disseminate and cascade key messages and information as appropriate.**

ICB/05/26/17 Cheshire and Merseyside ICB and System Finance Report – Month 1

The Board received an update on the year-end financial position for 2025/26 and the month 1 position for 2026/27 from AM. Subject to completion of the external audit, the ICB achieved its statutory financial duties and reported a year-end surplus of £30,000. This followed agreement with NHS England during the year to revise the original £50 million surplus plan to a breakeven position.

The wider ICS reported a deficit of £288 million, excluding deficit support funding, representing a £110 million adverse variance from plan. Whilst significant, this represented a marked improvement on earlier forecasts, which had indicated a variance of approximately £200 million. It was reported that this improvement had been supported through a range of measures, including Finance Performance Review Meetings with PWC for organisations facing the greatest challenge in delivering their financial plans.

The ICB's annual accounts will be considered by the Audit Committee on 9th June 2026 and returned to Board for approval on 18th June 2026, ahead of submission on 19th June 2026. NHS England is expected to review the ICB's undertakings during June, taking account of the revised ICB blueprint, the changing expectations regarding system oversight, and delivery against the current financial plan.

In relation to month 1 of 2026/27, a national systems issue had prevented direct ledger input. However, based on local assumptions and early indicators, the ICB is forecasting a breakeven position at month 1. Progress in relation to the CRES efficiency programme was noted, with a target of £144 million and identified schemes totalling £154 million. Whilst progress had been made in strengthening the deliverability of the programme, the plan remains highly challenging.

One provider contract remains unsigned and that work is continuing with the provider and NHS England to resolve the position.

The Board –
Noted the ICB financial position at month 1 (April 2026); and acknowledged the level of uncertainty associated with early-year reporting and the reliance on planning assumptions at this stage.

ICB/05/26/18 Highlight report of the Chair of the ICB Finance, Investment and Our Resources Committee

The Board received an update from the Chair of the Finance, Investment and Our Resources Committee, noting positively that the ICB had achieved its revised year-end financial plan and that early progress in the new financial year was encouraging, supported by strengthened financial controls. 15 of the 16 major NHS provider contracts have now been signed and the Committee supported the use of a formal route where agreement could not be reached on the remaining contract.

Ongoing complexities in relation to ambulance contracting remain, which continue to require interim arrangements and close oversight. The strengthened programme management of the CRES programme and the assurance provided through recent deep-dive reviews, with particular recognition given to the prescribing workstream for early delivery of its target was welcomed.

The Board noted the contents of the report.

ICB/05/26/19 NHS Cheshire and Merseyside Integrated Performance Report

The Board received an update on the Integrated Performance Report from JA, following discussion at the previous Board meeting, the contribution of Non-Executive Directors in helping to determine the hierarchy of metrics required at Board level and those more appropriately delegated to Board committees was noted. It was reported that the current report format would be replaced from the next meeting by a revised version structured around the life-course approach and aligned to the ICB's five-year strategy, enabling clearer links between performance monitoring and strategic objectives.

Members were asked to give particular consideration to relative ICB rankings as part of future performance reporting. Whilst some indicators may be rated positively against local targets, comparative performance may still remain below that of other ICB's. The importance of using comparative benchmarking to assess whether the pace of improvement is sufficient and whether progress is being made in reducing health inequalities across Cheshire and Merseyside was recognised.

The Board discussed the importance of ensuring that the new performance reporting arrangements include comparative information to support understanding of relative performance. Particular concern was raised in relation to healthcare-associated infection and sickness absence, where high levels in some provider organisations and the potential interrelationship between these indicators, antibiotic usage, financial pressure and wider organisational performance was noted. The importance of triangulating quality, operational, workforce and financial metrics to provide a coherent view of provider performance was highlighted.

The triangulation of performance information is undertaken through existing oversight arrangements, including work supported by PWC, the need to strengthen and refine this approach over time, including the use of comparators that better demonstrate direction of travel and relative improvement was emphasised. Concern was expressed regarding the need to ensure robust succession arrangements for provider oversight beyond the current PWC support.

The revised performance framework is being developed to focus on those measures most directly within the ICB's influence, alongside strengthened provider oversight arrangements. A new Contracts and Business Oversight Board has been established, through which deputies will review quality, cost, delivery and workforce metrics for each acute provider, with key issues escalated to Executive level and outputs reported through the Quality Committee and Finance Committee.

Provider performance metrics are significant not only for oversight purposes but also because of their direct relationship to control totals and the pace of required improvement within an over-allocated system.

The Board noted the contents of the report and took assurance on the actions contained.

ICB/05/26/20 Highlight Report of the Chair of ICB Quality and Performance Committee

The Chair of the Quality and Performance Committee provided an update to the Board highlighting that urgent and emergency care performance in Cheshire remains a significant system-wide risk, with particular concern regarding pressures in East Cheshire. This will remain under sustained oversight by the Quality and Performance Committee, with further detailed analysis of flow, productivity and no-criteria-to-reside metrics to be undertaken across the three providers and brought back for consideration.

Ongoing safeguarding concerns were noted, particularly in relation to delays in initial health assessments and the increasing pressure on multi-agency pathways arising from complex lives issues, including domestic abuse, exploitation, youth violence, suicide risk and self-neglect. While mitigations are in place, concern remains about the cumulative impact of paediatric workforce shortages and the need to identify more sustainable solutions in order to avoid adverse effects on vulnerable children. A detailed report on SEND was welcomed with new funding available through local authorities.

The Board noted the contents of the report.

ICB/05/26/21 Highlight report of the Chair of the Audit Committee

The Chair of the Audit Committee provided an update on the Committee which met in May for a single-item agenda to review the development of the Annual Report. The document is required to meet NHS England's prescribed reporting requirements and further revisions have been made to address comments raised both by the Committee and by NHS England on the initial draft. The Annual Report has improved significantly from the first draft and that work continues to ensure the final document presents a balanced and honest account of performance, supported by both appropriate data and narrative.

The Board noted the contents of the report.

ICB/05/26/22 Highlight report of the Chair of the Remuneration Committee

The Chair of the Remuneration Committee provided an update with the report provided in the meeting pack taken as read.

DRAFT

The Board noted the contents of the report.

ICB/05/26/23 Highlight report of the Chair of the System Primary Care Committee

Tony Foy provided and update to the Board as the Chair of the System Primary Care Committee sent apologies. The main areas of concern were workforce and resourcing risk within primary care, particularly in the context of ongoing organisational transition and restructuring, with concern that the system may lack sufficient capacity and capability to support key functions such as analysis, performance management and quality oversight. It was reported that this risk is recognised and is being actively managed. There is significant work being undertaken by the Committee in relation to primary care estates governance, this remains a complex and critical area, with a number of factors beyond local control, and that it is likely to remain at alert status for some time while further work continues.

The Board noted the contents of the report.

Closing Business

ICB/05/26/24 Closing Remarks and Review / Reflections of the Meeting

The Chair thanked all members for their contributions and reflected on the constructive and insightful discussions held throughout the meeting.

ICB/05/26/25 Any Other Business

None.

CONSENT ITEMS

The Board received and noted the items within the Consent Item section of the May 2026 Board.

Date and start time of future meetings

- 18 June 2026, 09:00am – online meeting to consider the ICB Annual Report and Accounts 2025-26. Joining details on the ICB website
- 30 July 2026. 14:00pm, Conference Suite, Riverside Innovation Centre, 1 Castle Drive, Chester, CH1 1SL

DRAFT

ICB Board Meeting Action Log

Updated: **22.06.26**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status	Recommendation to Board
ICB-AC-104	27/11/2025	Safeguarding Our Workforce – NHS Cheshire and Merseyside Sexual Misconduct Policy	ICB Sexual Misconduct Policy to be shared with higher education institutions through the deanery	Mike Gibney		ICB Sexual Safety charter and policy approved and available on the staff hub. NHS England North West (the postgraduate medical education deanery) introduced a national Sexual Misconduct Policy in October 2024 and operates a zero-tolerance approach.	ONGOING	Board is asked to approve removal of action
ICB-AC-105	27/11/2025	Board Assurance Framework	Board risk appetite session to be developed	Clare Watson	Q1 2026-25	To be incorporated as part of Board Development Programme in 2026 and as part of single improvement plan	ONGOING	Board is asked to approve removal of action
ICB-AC-114	28/05/2026	ICB/05/26/12 NHS Cheshire & Merseyside Antimicrobial Resistance and Infection Prevention & Control Update	FL to gather information on the numbers involved in the penicillin de-labelling programme and the percentage of people who are affected; together with data on primary care prescribing rates, including whether these rates relate soley to GP's or include other prescribers.	Fiona Lemmens	30/07/2026	Information provided on the 29 May 2026	ONGOING	Board is asked to approve removal of action

NHS
Cheshire and Merseyside

Meeting of the NHS Cheshire and Merseyside Board

Date: 30th July 2026

The Ockenden (Nottingham) and Amos Maternity Reviews

Agenda Item No: ICB/07/30/26/09

Responsible Director: Kerry Lloyd – Chief Nursing Officer

1. Purpose of the Report

The report provides the Board with a summary of the key findings from the 2026 Nottingham Ockenden Review, published 24th June 2026 and the National Maternity and Neonatal Investigation (Amos) report published 30th June 2026 with the subsequent NHS England response.

The report highlights the implications for NHS Cheshire and Merseyside and outlines the actions expected of providers, systems and boards to support delivery of safe, equitable and high-quality maternity and neonatal services.

2. Ask of the Committee and Recommendations

The Committee is asked to:

- **Note** the content of this report
- **Request** future system response/s to the report findings

3. Reasons for Recommendations

This report is for noting but future reporting will support the Board in receiving the necessary assurance on the system response, alongside identified risks.

4. Summary of Ockenden and Amos Report Findings

4.1 Introduction

The Ockenden and Amos reports reach the same fundamental conclusion: avoidable maternal and neonatal harm continues to occur, and not because the NHS lacks recommendations for improvement, but because it has consistently failed to implement and sustain learning, accountability, effective leadership, and meaningful cultural change.

The Amos National Maternity and Neonatal Investigation provides a national blueprint for maternity reform through a whole-system assessment of the challenges facing maternity and neonatal services across England.

The Nottingham Ockenden Review, the largest maternity inquiry in NHS history, involved contributions from more than 2,500 families and examined care provided between 2012 and 2025. The review was triggered by concerns regarding patient harm and a loss of public confidence. The review provides a stark example of how failures in governance, leadership, organisational culture, workforce planning, and engagement with families can persist over many years within a large NHS organisation, in this review - Nottingham University Hospitals NHS Trust.

Considered together, the Amos and Ockenden reports provide the strategic case for national reform and a clear illustration of the consequences of failing to deliver sustained improvement.

The overarching themes are:

- Women and families are not consistently listened to.
- Safety concerns are not escalated or acted upon reliably.
- Racism, discrimination and inequalities are embedded within services.
- Workforce pressures and poor culture undermine safe care.
- Governance arrangements are fragmented and accountability unclear.
- Learning from incidents is inconsistent and often not translated into improvement.
- Significant variation in care remains across England.
- Board oversight is often insufficiently challenging or connected to frontline reality.

4.2 Ockenden 3 Review: Nottingham University Hospitals Trust 2026

The Ockenden Review of Nottingham University Hospitals NHS Trust is the largest maternity inquiry in NHS history. The review considered the experiences of more than 2,500 families who received maternity care between 2012 and 2025.

The review identified longstanding and systemic failures across multiple areas, including:

- Governance and organisational oversight
- Clinical leadership and accountability
- Incident reporting, investigation and learning
- Workforce shortages and staffing capacity
- Organisational culture, including evidence of a toxic working environment
- Failure to listen to, engage with, and respond to the concerns of women and families

Key Findings

Many of the themes identified in Ockenden 3 mirror those highlighted in previous maternity investigations, including:

- Morecambe Bay
- Shrewsbury and Telford
- East Kent

This demonstrates the persistence of recurring safety, leadership, workforce and cultural challenges across maternity services despite previous national reviews and recommendations.

The report sets out eight key themes for Immediate and Essential Action (IEAs), comprising 18 Immediate and Essential Actions and 72 supporting actions in

total. At the time of writing, these recommendations have not yet been formally adopted in full by NHS England.

The immediate recommendation from NHS England (NW region) team is for providers and ICBs to review and understand the findings of the report, while providers undertake a local gap analysis against the Immediate and Essential Actions. Systems are advised to await further guidance from the National Maternity Taskforce (described in section 4.4) to support a coordinated and consistent national response. Providers across Cheshire and Merseyside are currently undertaking their own gap analyses. The outcomes of these reviews will help inform local improvement priorities and provide assurance regarding compliance with the Immediate and Essential Actions identified by the Review.

Alignment with the Amos Review

The Ockenden 3 recommendations strongly reinforce many of the themes and priorities identified within the Amos National Maternity and Neonatal Investigation.

Listening to Women and Families
The review identified repeated examples of:

- Women's concerns being dismissed
- Reduced fetal movement not being appropriately acted upon
- Delayed escalation of clinical concerns
- Women and families not feeling listened to or believed

Standardising Escalation and Risk Assessment
The report highlights the need for greater national consistency in:

- Maternity triage processes
- Fetal assessment and monitoring
- Recognition and management of clinical deterioration
- Escalation pathways and decision-making

Workforce Improvement
Significant workforce deficits were identified, with direct implications for patient safety, particularly within:

- Midwifery
- Obstetrics
- Neonatal services

Strengthening Governance
Boards are expected to demonstrate greater oversight of maternity services by:

- Understanding maternity-specific risks
- Robustly challenging assurance processes
- Escalating safety concerns appropriately
- Monitoring implementation of learning and improvement actions

Improving Organisational Culture
The review highlights the need to address:

- Bullying and undermining behaviours
- Toxic workplace cultures
- Barriers to speaking up
- Psychological safety for staff

Reducing Inequalities
The report places particular emphasis on addressing disparities in outcomes and experiences for:

- Black women
- Asian women
- Women living in areas of deprivation
- Women and families whose first language is not English

4.3 National Maternity and Neonatal Investigation (Amos)

The National Maternity and Neonatal Investigation (Amos) was commissioned to answer a critical question:

> *'Why do avoidable maternal and neonatal deaths and harm continue despite multiple national reviews and hundreds of recommendations?'*

The review engaged extensively with women, families, staff and stakeholders across England, including:

- More than 450 families
- Over 10,500 public responses
- More than 9,000 staff
- Multiple NHS Trusts and system partners

The investigation concluded that the maternity and neonatal system is:

- Fragmented
- Overly complex
- Insufficiently accountable
- Poor at learning from harm and implementing improvement
- Not designed to manage current levels of complexity and demand

A key finding was that 895 recommendations have been published since 2014, yet many of the same safety, culture and workforce issues remain unresolved. The report concludes that the challenge is not a lack of recommendations, but a lack of consistent implementation, accountability and sustained leadership.

Key National Recommendations

The Amos review key national recommendations have been accepted in full by NHS England:

- **Establish a Statutory Maternity and Neonatal Commissioner** – Creation of a new national role accountable to Parliament, responsible for:
  - Driving system-wide reform
  - Monitoring implementation of recommendations

- Holding organisations to account
- Ensuring the voices of women and families remain central to decision-making

- **Introduce a Modern Service Framework** - Development of a national framework to support the redesign of maternity and neonatal services, including standards for:
  - Safety
  - Workforce
  - Triage
  - Incident investigation
  - Neonatal care
  - Postnatal care
  - Digital interoperability

- **Make Listening to Women a Safety Metric** - The report recommends that feedback from women and families should be treated as a core source of patient safety intelligence and incorporated into:
  - Board assurance processes
  - Quality and safety reporting
  - Regulatory assessments and inspections
  - **Treat Racism and Inequality as Patient Safety Issues** - The report is clear that inequalities in maternity outcomes represent a patient safety issue, rather than solely an equality, diversity and inclusion concern. This requires:
  - Active Board oversight
  - Routine analysis of equity data
  - Targeted improvement plans
  - Regulatory scrutiny and accountability

- **Improve Investigations Following Harm -** Recommendations include:
  - Independent investigations where families remain dissatisfied
  - Better training for investigators
  - National sharing of learning
  - Greater transparency and accountability

- **Strengthen Leadership and Culture** - The report identifies the need for:
  - Strong joint midwifery and obstetric leadership
  - Multidisciplinary learning and training
  - Trauma-informed approaches to care
  - Improved workplace behaviours
  - Psychological safety for staff

- **Digital and Estates Investment** - National investment is proposed over the short, medium and long term to support:
  - A single digital maternity record
  - Improved interoperability between systems
  - Modern, safe maternity and neonatal facilities

Implications for ICB's, NHS England Regional Teams and Provider Boards

ICB's and Regional Teams

Both the Amos and Ockenden reports place greater emphasis on regional leadership, assurance and oversight. Key responsibilities include:

- **Safety Assurance** - Regional teams and ICBs should provide oversight of:
  - Monitoring of maternity and neonatal outcomes
  - Oversight of maternity safety indicators
  - Emerging risks and deteriorating performance
  - Appropriate escalation arrangements

- **Implementation Monitoring – systems should monitor delivery of:**
  - Ockenden recommendations
  - Amos recommendations
  - CQC actions and regulatory requirements
  - Maternity Incentive Scheme standards

- **Shared Learning - Regional arrangements should support:**
  - Dissemination of learning
  - Reduction of duplication
  - Collaboration across providers
  - Adoption of best practice

- **Equity Oversight - Routine monitoring should include:**
  - Maternal mortality
  - Stillbirth rates
  - Neonatal mortality
  - Experience measures
  - Ethnicity and deprivation outcomes

Local Provider Board Implications

Provider Boards are expected to provide visible leadership and assurance across the following key domains.

- **Safety -** Boards should receive assurance regarding:
  - Triage performance
  - Delays in escalation and treatment
  - Perinatal Mortality Review Tool (PMRT) themes
  - Maternity and Newborn Safety Investigations (MNSI) findings
  - Incident trends and learning

- **Culture** – Boards should monitor:
  - Freedom to Speak Up indicators
  - Bullying and harassment concerns
  - Staff survey results
  - Multidisciplinary working and team culture

- **Family Voice -** Feedback from women and families should be considered as core Board-level intelligence, including:
  - Complaints and concerns
  - Patient Reported Experience Measures (PREMs)
  - Maternity and Neonatal Voices Partnership (MNVP) feedback
  - Birth trauma and bereavement feedback

- **Equity -** Boards should receive regular assurance on:
  - Outcomes by ethnicity
  - Outcomes by deprivation
  - Access and experience measures
  - Use of interpretation and translation services

4.4 National Maternity and Neonatal Taskforce

The National Maternity and Neonatal Taskforce was established to address systemic safety, quality and cultural challenges within England's maternity and neonatal services. Chaired by the Secretary of State for Health and Social Care, the Taskforce has been established to drive national improvement and oversee implementation of the recommendations arising from Baroness Amos's Independent Investigation into NHS Maternity and Neonatal Services.

The Taskforce is responsible for developing a comprehensive National Action Plan in response to the final report published on 30th June 2026. The Action Plan will set out both immediate priorities and longer-term reforms designed to improve safety, outcomes, accountability, leadership, workforce sustainability, service culture, and the experience of women, babies and families.

The Taskforce is expected to publish its National Action Plan in December 2026. This will provide the national framework for implementation and will guide the actions required at national, regional, system and provider levels to deliver sustained improvement across maternity and neonatal services.

4.5 NHS England Response

Following publication of the National Maternity and Neonatal Investigation and the Ockenden 3 Nottingham Review, NHS England wrote to all Trusts, ICBs and regional leaders on 30th June 2026, describing the reports as a significant turning point for maternity and neonatal services (See Appendix A).

The NHS England letter emphasises that the system can no longer rely on repeated reviews and recommendations in response to maternity services failures. Instead, organisations are expected to demonstrate tangible improvements through effective implementation, strengthened accountability, and sustained leadership. To support this, NHS England has identified 10 urgent actions, each with defined delivery timescales, which all Trusts and systems are expected to prioritise.

4.6 Key Messages for the Board

The focus must shift from recommendations to implementation. Boards are expected to demonstrate visible leadership, stronger accountability, greater engagement with women and families, improved equity, safer maternity triage, compassionate responses when things go wrong, and sustained delivery of maternity and neonatal improvement across systems.

Boards are expected to demonstrate visible leadership, ensure the voices of women and families influence decision-making, address inequalities in outcomes and experience, strengthen maternity safety and culture, and provide robust oversight of progress against national and local improvement priorities.

4.7 Cheshire and Merseyside System Response

Work is already underway across Cheshire and Merseyside to review the findings of both reports. Provider organisations are undertaking local assessments against the Ockenden Immediate and Essential Actions, while the LMNS will coordinate a system-wide response to support implementation of national priorities. Further updates will be provided to the Board as the National Maternity and Neonatal Action Plan is published and local implementation plans are developed.

5. Officer contact details for more information

Kerry Lloyd – Chief Nursing Officer

6. Appendices

NHS England Letter

NHS England

To:
- NHS trust and ICB:
  - chief executives
  - chairs
  - chief nursing officers
  - medical directors
  - chief operating officers

cc.
- NHS England region
  - regional chairs
  - regional directors
  - medical directors
  - chief nursing officers
  - chief midwifery officers
  - regional obstetricians

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

30 June 2026

Dear colleagues,

Publication of Baroness Amos' independent investigation into maternity and neonatal services in England

Thank you for joining today's event and contributing to our conversation about maternity and neonatal services. I don't think anyone who attended today could have been anything other than deeply moved by what we heard and discussed.

This is a moment in our history that requires our collective leadership to act with real urgency in addressing the failings and harm experienced by women, babies and families and improve maternity and neonatal care.

None of this is going to be easy, but we all agreed today that this must be a turning point for maternity and neonatal services in the NHS. Women, babies, and families deserve better, as do our colleagues working in these services.

As set out during the event today, we have created a 10 Point Plan for maternity and neonatal services (see Annex 1), taking those elements from Baroness Amos' national

investigation and Donna Ockenden's recent review that we must focus on delivering now. This is a set of urgent actions in response to the recommendations in both reports that we are asking trusts and the wider system to prioritise.

These urgent actions will support, and report into, the National Maternity and Neonatal Taskforce as it develops the National Action Plan, which will be published in December. Further information and a reporting template will be shared soon.

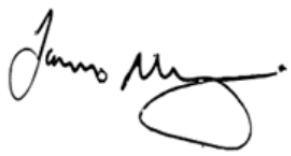
In response to the Amos report, the government has also announced NHS England will make £10.6 million available in 2026/27 to support the recruitment of newly qualified midwives, helping them enter and remain in the NHS while strengthening frontline maternity capacity. See Annex 2 for further information.

The government also announced the creation of the UK's first ever Maternity and Neonatal Commissioner, providing an independent voice to strengthen focus on safety, experience, equity and accountability for women, babies and families. Alongside this, an additional £41 million will be invested to improve the safety and quality of the maternity and neonatal estate, supporting better environments for those using and working in maternity and neonatal services.

As we heard today, this must be a turning point for the NHS. Trusts and systems have already prioritised improving maternity and neonatal care, and progress has been made through the commitment and hard work of staff. We cannot allow failures in care to persist and be followed by reviews that continuously highlight the same themes.

Thank you for your leadership as we respond and move forward together with urgency to deliver lasting change for women, babies and families, and rebuild trust and confidence in maternity and neonatal care.

Yours sincerely,



Sir James Mackey
Chief Executive Officer

Annex 1

Urgent Actions

Action	Description
Listening to women and their families by rolling out Martha's Rule	Commence roll out of Martha's Rule across all maternity and neonatal services in 2026/27. Building on the learning and insights from the recent pilot, this next phase will support implementation in all antenatal, intrapartum and postnatal inpatient maternity and obstetric settings, including maternity triage and assessment units, and neonatal settings. Implementation will be led by the national Martha's Rule programme team, working closely with patient safety collaboratives to provide coordinated local support, webinars, guidance and advice. We will contact provider organisations in the coming weeks to confirm expectations, resources and timelines.
Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit data that are acted upon at board level	All trusts should implement a monthly cycle of collecting and analysing real-time patient outcomes and experience data at their public boards, using locally meaningful measures like the friends and family test, selected elements of PREM (when available) and insights from maternity and neonatal voices partnerships (MNVPs). This should include regularly listening to women, families and neonatal

	parents at different points in the pathway, publishing data and patient commentary for full transparency, and ensuring a clear focus on the experiences of people from minority backgrounds. This will ensure the voices and experiences of women and families are heard, scrutinised and acted upon by boards. As part of this, trusts should also reinvigorate clinical audits focusing on key and relevant recommendations identified in the Ockenden and Amos reviews in a focused and effective way, and act on the findings. The aim is to support this approach through national webinars.
Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	All trusts must establish clear joint accountability at board level for maternity and neonatal services, with medical directors and chief nurses holding shared responsibility for oversight, performance and improvement. This must include consistent medical director engagement alongside the chief nurse, and parity between obstetric, midwifery, neonatal and operational leadership. Directors of midwifery and clinical directors leading maternity and neonatal services should attend boards when maternity or neonatal matters are discussed. This should also be implemented across all levels in the NHS including at system, regional, and NHS England boards to eliminate siloed working and strengthen system-wide leadership.
'Amos into action' staff listening exercise	Following the listening conversation undertaken by Baroness Amos to understand the nature of the issues in maternity and neonatal services, NHS England will launch a full, open conversation with NHS staff and leaders to identify how the recommendations can be implemented across the system. It will explore and help address the role of culture, attitudes, approaches to practice and ways of working – bringing staff into the single largest national

	conversation about what trusts and individual clinicians need to do differently to implement both the letter and spirit of the Amos recommendations. This will be done in a way that aligns to rather than duplicates the work of the taskforce and will report findings into it. It will focus on how we implement Baroness Amos's findings from the listening exercise and the findings of the Ockenden review of Nottingham University Hospitals NHS Trust (NUH).
Addressing inequalities in maternity and neonatal outcomes	We can now confirm the timeline for national rollout of the Perinatal Equity and Anti-discrimination Programme, which will be available to all trusts by the end of 2026. The programme has been developed to support maternity and neonatal teams to tackle racism and discrimination, improve the experiences and outcomes of ethnic minority groups and those from deprived communities, and support staff to work in environments free from discrimination and racism. All boards must ensure that provision is in place to allow enough staff to be released to complete the Perinatal Equity and Anti-discrimination Programme, with full participation expected across multi-disciplinary teams. Boards must also regularly review and act on trends identified by their inequalities data dashboards: Maternity and Neonatal Equalities dashboard - NHS England Digital All NHS trusts providing maternity services are responsible for fully implementing the Maternal Care Bundle by March 2027. This includes providing regular reports to the trust board on implementation.
Ensuring 24/7 safety and responsiveness of maternity and neonatal services	All boards must take accountability for ensuring safe and effective service arrangements, including reviewing staffing to ensure 24/7 availability and responsiveness across key workforce groups. Boards must also review internal resource deployment and consider whether roles not directly supporting frontline delivery can be redirected to strengthen service provision. Trusts must ensure that, where specialist posts exist (including in

	bereavement care and infant feeding), other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available. Commissioners also hold responsibility for ensuring that their maternity and neonatal service model aligns to local demographic needs. Boards and commissioners must address local gaps and eliminate siloed working to ensure services can consistently and safely respond to the needs of women, babies and families.
Trusts to review their homebirth services	Trusts have a continuing responsibility to offer homebirth as a choice for women and are responsible for ensuring that they manage their workforce to enable this. In November 2025, the Chief Midwifery Officer for England asked trusts to urgently review the safety and quality of their homebirth services. Trusts should ensure that this review has been undertaken and reported to their board and that any safety concerns requiring urgent attention have been actioned. They should ensure that improvement plans are in place where necessary and that risks have been communicated to their regional NHS England team. NHS England is working with partners to develop homebirth standards and a homebirth framework, to support women's autonomy, choice and personalised care, and to help services provide safe homebirth care.
Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach	Trust boards should review how they are responding to patient safety incidents, complaints and concerns within maternity and neonatal services, with openness, humanity and candour.

	We will work with trusts, in alignment with the work of the national taskforce, to develop a blueprint for how organisations and leaders can respond with more humanity and compassion when things go wrong with a patient's care.
Deliver safe and effective triage in maternity services (already committed by Government)	All trusts must commit to delivering safe and effective triage, starting by completing a board-level audit within 3 months, with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced. This will be supported by new NHS England guidance, which will be published this week. This includes having dedicated midwifery staffing to answer calls and provide face-to-face assessments, separate from other services such as the labour ward. Services should also have enough clinical, antenatal and bed capacity, with clear escalation routes in place at all times, including overnight and at weekends. Boards should have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes. Triage records should capture women's preferences, and services should use evidence-based standards, such as BSOTS, supported by rapid assessment training for triage midwives. This should enable trusts to identify risks, address delays and provide women with timely, consistent and high-quality triage care. The outcomes of this audit should be reported to regions and the Department of Health and Social Care / NHS England. Within 12 months, trusts must implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS. National maternity triage principles and a supporting measurement framework will be provided to trusts this week to reduce unwarranted variation, strengthen consistency in how concerns are assessed and escalated, and provide a clearer basis for local, regional and national improvement.

Post death care (already committed by Government)	All trusts must implement actions set out in the System letter following the Fuller and NUH reviews, including responding to the board assurance statement by 31 July and to the Human Tissue Authority requirement to review and assure completeness of incident records over the past 10 years. Every board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.

ANNEX 2

Support for the recruitment of newly qualified midwives

The government has invested in expanding midwifery training, resulting in a strong pipeline of newly qualified candidates. Maternity services have also undertaken significant work to recruit, support and retain newly qualified midwives, including through preceptorship and flexible workforce models. There is now an opportunity to maximise the benefit of this investment by ensuring newly qualified midwives are able to enter employment promptly and contribute to increasing frontline capacity.

National offer for 2026/27

NHS England will make £10.6 million available in 2026/27 to enable the recruitment of newly qualified midwives. £9 million of this funding will be recurrent and incorporated into provider baselines from 2027/28 to support ongoing workforce growth and service stability.

The funding is intended to support providers to create additional temporary Band 5 midwifery roles, over and above planned recruitment. It should support recruitment ahead of future turnover and, where appropriate, enable temporary recruitment above establishment to increase clinical capacity and support safe staffing.

As in 2025/26, providers should explore the temporary uplift and utilisation of vacant maternity support worker roles to enable the creation of additional Band 5 midwifery posts, providing a structured route for newly qualified midwives to transition into substantive employment as vacancies arise.

Funding must be used to deliver additional employment opportunities and should not be used to fund posts already planned within existing workforce plans or budgets.

NHS England regional teams will work with systems and providers to support delivery and ensure the offer reflects local workforce needs.

Expectations of systems and providers

Providers should continue to strengthen early career support, including high-quality preceptorship, supervision and pastoral support, to improve retention and support early career development. This investment should also inform longer-term workforce planning, supporting sustainable growth in midwifery capacity.

Organisations should work in partnership with staff side representatives and maintain clear communication with students and graduates to support confidence in NHS employment pathways.

Implementation, monitoring and assurance

Funding will be distributed through existing mechanisms, with further detail to follow. Regional teams will work directly with systems and providers to support implementation and ensure funding is applied effectively.

A national monitoring and assurance approach will track delivery and impact, focusing on evidence of additional employment opportunities, increases in frontline workforce capacity and improvements in newly qualified midwife employment outcomes.

Progress will be monitored through established workforce reporting arrangements and used to inform future workforce planning and policy development.

Next steps

Further operational guidance, including allocation details and reporting requirements, will follow shortly.

Organisations are asked to begin early planning and engagement locally to ensure rapid mobilisation following publication of Baroness Amos' investigation report.

NHS
Cheshire and Merseyside
Provider Collaborative

Annual Work Plan

Delivery Priorities for 2026/27

Image: University Hospitals of Liverpool Group

Contents

Introduction

Cheshire and Merseyside Provider Collaborative (CMPC) consists of all 15 NHS provider trusts across Cheshire and Merseyside, encompassing acute, specialist, community and mental health services.

Supported by a highly experienced programme team, we work collectively and alongside Cheshire and Merseyside's Integrated Care Board (ICB) to respond to the challenges that we currently face – those which cannot be solved by any single organisation, alone.

These include clinical fragility, workforce pressures, unwarranted variation and the need for long-term financial sustainability, all while protecting local access and improving patient outcomes.

Collaboration at the right scale is vital. CMPC members work together as a whole or in smaller clusters, depending on shared goals. This approach has already delivered significant results. In 2025/26, we secured £50 million of diagnostic funding and enabled NHS Cheshire and Merseyside to maintain its strong position in the top 4 Integrated Care Systems for diagnostic waiting time performance.

We also supported the delivery of over £40 million efficiency savings, reduced 52-week waiting lists by 39% in elective healthcare and increased Virtual Ward referrals by 51%. In addition to this, our introduction of dermatology AI pathways resulted in over 4,500 unnecessary face-to-face appointments being avoided.

Critical to our future success, is the CMPC Provider Strategy (CMPC Provider Blueprint), developed by and for the CMPC provider trusts. This is a robust response to the national context and direction for NHS providers, including the NHS Medium-Term and 10 Year Health Plans.

This provides a clear framework that will enable us to realise the benefits of working at scale, not least through the consolidation of corporate and clinical support functions over larger footprints, releasing capacity and resources back into frontline care. Through it we can strengthen fragile clinical services, better support neighbourhood-based care, reduce duplication and create sustainable provider models fit for the future. Collectively, we hold the leadership, governance and capability needed to turn this ambition into action, supporting trusts to work differently, together.

Equally integral to achieving our delivery priorities for 2026/27 and beyond, are the CMPC's Programme Plans. These focus on what matters most: efficiency at scale, recovery and transformation in elective and diagnostic services, community and clinical pathways.

Our vision is to work collectively for a single healthcare system, to provide high quality, timely, efficient, productive and sustainable services to everyone in Cheshire and Merseyside.

We are proud to share the CMPC's Annual Work Plan for 2026/27. It is only through the harnessing of our collective experience, skills and passion for better, more equitable patient healthcare, that we will truly make our vision a reality. Together, we are stronger.

Janelle Holmes
Joint Chief Executive
Wirral University Teaching Hospital NHS Foundation Trust and Wirral Community Health and Care NHS Foundation Trust

Linda Buckley
Managing Director
Cheshire and Merseyside Provider Collaborative

About us

Cheshire and Merseyside Provider Collaborative was formed on 1 May 2025, when Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) and the Mental Health, Learning Disability and Community Provider Collaborative (MHLDC), separate entities since 2021, merged.

Already we are realising the benefits of this one co-ordinated system, encompassing specialist, mental health, learning disability, and community providers.

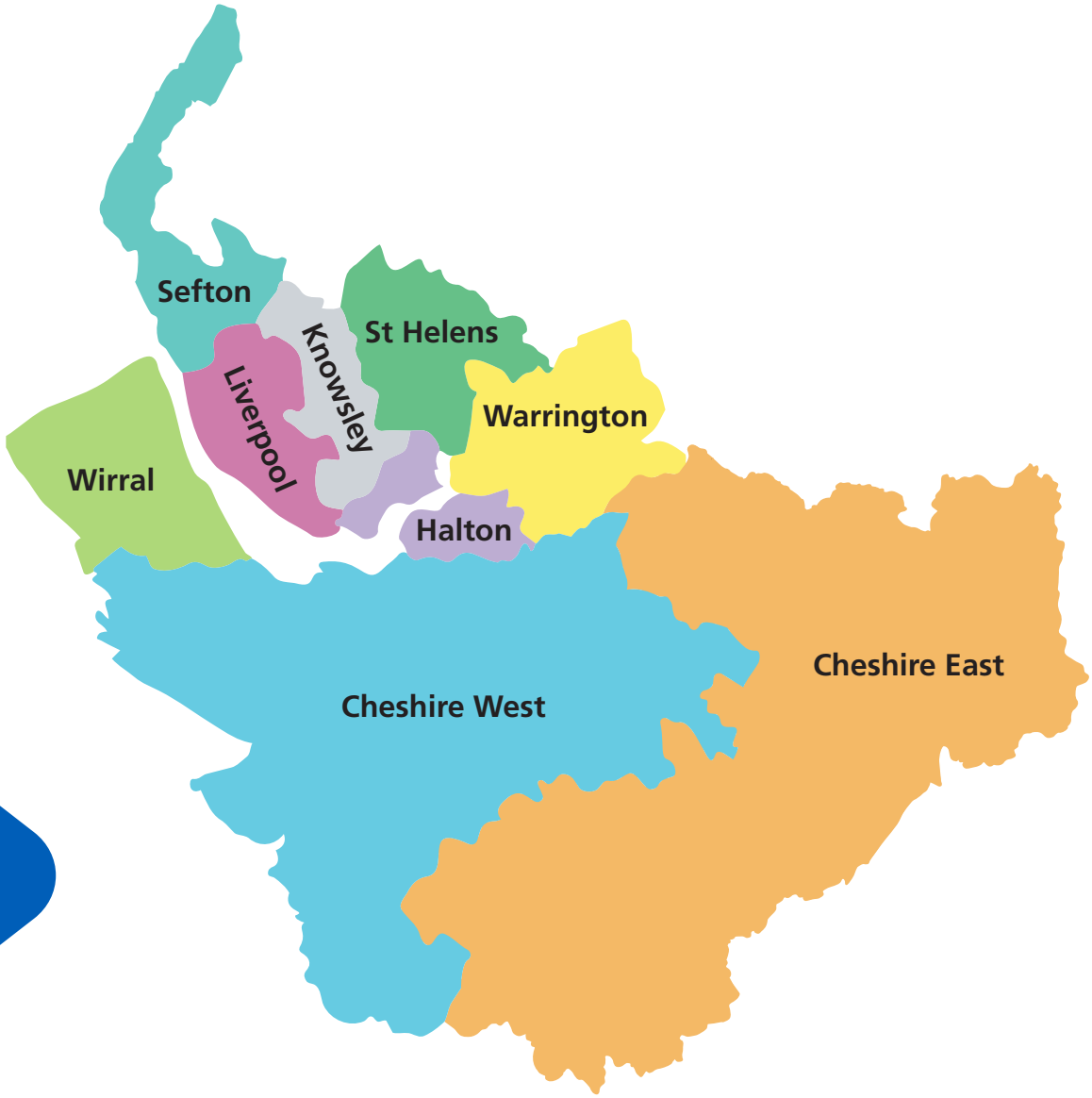
Between us we provide a range of health and care services, with several specialist areas including paediatrics, neurology, cancer, cardio-thoracic and women's.

We are supported by a highly experienced CMPC programme team, drawn from specialist areas and chosen for their combined expertise.

Fair and equal collaboration is key to our success. We have a joint working agreement, robust Governance Framework and a Committee in Common, enabling delegated system decision making, where required.

Together, we are committed to providing the highest quality healthcare that will meet our communities' changing needs.

Image: Mersey and West Lancashire Teaching Hospitals NHS Trust



The CMPC is all 15 provider trusts within Cheshire and Merseyside

- Alder Hey Children's Hospital NHS Foundation Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- The Clatterbridge Cancer Centre NHS Foundation Trust
- Countess of Chester Hospital NHS Foundation Trust
- East Cheshire NHS Trust
- University Hospitals of Liverpool Group (Liverpool Heart and Chest Hospital NHS Foundation Trust, Liverpool University Hospitals NHS Foundation Trust and Liverpool Women's NHS Foundation Trust)
- Mersey and West Lancashire Teaching Hospitals NHS Trust
- Mersey Care NHS Foundation Trust
- Mid Cheshire Hospitals NHS Foundation Trust
- North Cheshire and Mersey NHS Foundation Trust
- Wirral Community Health and Care NHS Foundation Trust
- Wirral University Teaching Hospital NHS Foundation Trust
- The Walton Centre NHS Foundation Trust
- North West Ambulance Service NHS Trust*

*CMPC partner

Our impact in 2025/26

Just few of the ways in which we've been transforming healthcare across Cheshire and Merseyside…

Efficiency at Scale Programme

- Facilitated delivery of **£14 million non-pay efficiency savings**
- Supported delivery of over **£30 million in medicines efficiencies**

Clinical Services Transformation

- **Ophthalmology single point of access pilot** in 5/9 Places **avoided circa 1,600 unnecessary outpatient appointments** and provided a centralised patient choice process
- **Introduction of dermatology AI pathways** resulted in **29%** of Urgent Suspected Skin Cancer referrals being discharged **(4,640 unnecessary face to face appointments avoided), £1.8 million additional CDC income**, plus **efficiency savings** from reduced outpatient appointments and biopsies

Elective Reform and Transformation Programme

- **39% reduction** in patients waiting **52 weeks** or more
- **93% reduction** in patients waiting **65 weeks** or more

Diagnostics Programme

- **Top 4 ICS ranking** throughout the year for patients seen **within 6 weeks** and **top 2 ranking** throughout the year for patients waiting **13 weeks or less**
- **21% improvement** in sleep study waiting time performance, resulting in **number 1 ICS ranking**
- **10 Community Diagnostic Centres operational** (with a further 2 planned) **providing 7 day week access** (where needed)

Community Programme

- **27% increase** in patients seen by Urgent Community Response services
- **51% increase** in Virtual Ward referrals
- Identification of a **cost saving opportunity for providers** of **over £5.5 million**

Plan for 2026/27

Image: Mid Cheshire Hospitals NHS Foundation Trust

Image: Mersey Care NHS Foundation Trust

The CMPC Provider Strategy

In August and September 2025, CMPC's providers developed a strategic framework to collectively address the challenges facing them, both now and in the future:

- Clinical fragility
- Workforce pressures
- Unwarranted variation
- Long-term financial sustainability
- Improving outcomes for patients

Whether these stem from national and regional directives, demographic shifts, or evolving medical needs, it is essential to recognise that no single organisation can address them in isolation.

The result was the CMPC Provider Strategy (CMPC Provider Blueprint).

Fundamental to our plan for the next three years, this sets out a shared framework for how we, as provider organisations across Cheshire and Merseyside, can align to work at scale, flexibly and over time to strengthen our services, reduce fragility and support neighbourhood-based care.

Levers for change

The CMPC Provider Strategy brings together five interconnected levers to enable this change

The creation of provider groups, alliances and partnerships

To create scale, resilience and shared leadership across geographies

Developing service chains for specialist care

To reduce clinical fragility and improve access to expertise closer to home

The transformation of fragile clinical services

To protect quality and workforce sustainability where services cannot safely standalone

The alignment of community services to Place/ integrated care footprints

To support neighbourhood health, integration and the shift from hospital to community

The consolidation of corporate and clinical support functions on larger footprints

To release capacity and resources back into frontline care

Working together for successful delivery

Through our collective strength and supported by the dedicated CMPC programme team, together, CMPC's providers hold the leadership, governance, shared capability and pace required to successfully deliver the CMPC Provider Strategy.

The CMPC's four core functions will drive the CMPC Provider Strategy forward.

CMPC function	What this means in reality
System leadership	Creating shared strategic direction where national policy requires change
Enablement	Providing expertise, programme support and frameworks, so that each trust is not working alone
Pace and grip	Moving from discussion to implementation across groups, services and functions
Assurance	Ensuring changes improve quality, workforce sustainability and value

Real life results, for better patient care

Through the CMPC Provider Strategy we will deliver significant transformation, with more resilient services, better patient outcomes, stronger workforce sustainability and a system that can live within its means, while keeping care as local as possible.

Together, we will turn it into action, supporting each other to move at pace, protecting quality and improving outcomes for the populations we serve.

Clinical Services Transformation

Clinical Services Transformation forms a core part of the CMPC Provider Strategy. Here, we use a co-ordinated, system-wide approach to strengthen services experiencing sustainability pressures driven by workforce shortages, scale limitations and operational variation.

By bringing CMPC's providers together around their shared challenges, we are able to deliver improvements that cannot be achieved in isolation, reducing unwarranted variation, improving safety and resilience, supporting long-term clinical and financial sustainability, all for better patient care.

With its focus on collaboration, hosting models and service chain development, Clinical Services Transformation directly supports the aims of the CMPC Provider Strategy.

Image: Mersey and West Lancashire Teaching Hospitals NHS Trust

Clinical Services Transformation

Just a few of our achievements for Cheshire and Merseyside 2024-26

Ophthalmology single point of access pilot in 5/9 Places

- Circa **1,600 unnecessary outpatient appointments avoided** over 12 months
- Procurement now underway for a **long-term commissioned model**

Image: North Cheshire and Mersey NHS Foundation Trust

Community Musculoskeletal project

- **5 providers** utilised NHS England funding to **validate waiting lists** and **resource additional clinic days**
- **3/5 providers** piloted **Digital Triage and Routing tool,** which achieved **85% patient satisfaction score**
- Achieved a **70% reduction in 18 plus week waits** to January 2025

DERM AI project

- **£1 million national funding** was used to introduce **dermatology AI pathways,** utilising DERM AI technology
- **29%** of Urgent Suspected Skin Cancer referrals discharged **(4,640 unnecessary face to face appointments avoided)**
- **£1.8 million additional CDC income,** with additional **efficiency savings** from reduced outpatient appointments and biopsies

Clinical Services Transformation Plan 2026/27

In 2026/27, the Clinical Services Transformation plan moves from short-term stabilisation to a structured, medium-term model. This is aligned with the NHS Medium-Term Planning Framework, 10 Year Health Plan and the collaborative ambitions of the CMPC Provider Strategy.

It also builds on the strong progress made in 2025/26, where system level collaboration, innovation and data driven redesign delivered significant improvement across several pathways.

Collectively, these achievements demonstrate our ability to apply innovation, embed digital tools, redesign pathways and deliver cross-organisation solutions that stabilise fragile clinical services, reduce acute demand and delays and improve patient outcomes.

To ensure long-term resilience and system sustainability, we will focus on the following key strategic objectives, all of which directly support the CMPC Provider Strategy priorities of collaboration, hosting models and service chain development. Through this approach, our fragile clinical services will operate both safely and sustainably.

Key strategic objectives

Identifying fragile clinical services

We will implement a unified, system-wide, data driven approach to assessing and prioritising fragile clinical services. In doing this, we can ensure that left shift is embedded in pathway redesign and that the plan is aligned to ICB ambitions.

Adopting best practice pathway redesign

Using best practice we will standardise and redesign pathways to reduce variation, improve quality and safety, and embed evidence based practice. This will enable the identification of opportunities to move diagnostics, monitoring and ongoing management into community and primary care settings. In this way, care can be delivered earlier, closer to home and outside of acute hospitals.

Supporting left shift pathway changes

Here, our focus is on accelerating the movement of appropriate care from hospital to community settings, reducing acute pressures and improving access. Through the utilisation of digital tools such as virtual care, remote monitoring and system-wide data platforms, we will further enhance community management.

Optimising CMPC clinical networks / alliances

2026/27 will be a year of strategic consolidation and operational acceleration. By strengthening clinical networks and alliances we can support both service delivery at scale and hosted service models. Through this we will create a more resilient workforce and enable specialists to support community-based care, through shared governance and flexible workforce arrangements.

As part of this, the establishment of the Cheshire and Merseyside Clinical Reference Group provides the clinical governance needed to validate prioritisation, shape service model options and support coherent system level decision making.

Image: University Hospitals of Liverpool Group

Cheshire and Merseyside Provider Collaborative Programmes

Whilst the CMPC Provider Strategy addresses the key systematic challenges we, as trusts, all face, our CMPC Programmes continue to support the achievement of our agreed strategic priorities of clinical improvement and transformation, sustainability and value. Our Community Programme in particular, also links more directly with the CMPC Provider Strategy.

<table>
<tr><td colspan="3">Clinical improvement and transformation</td><td rowspan="2">CMPC strategic priorities</td></tr>
<tr><td colspan="3">Sustainability and value</td></tr>
<tr><td colspan="3">CMPC Provider Strategy</td><td>Clinical Services Transformation</td></tr>
<tr><td>Elective Reform and Transformation</td><td>Efficiency at Scale</td><td>Diagnostics</td><td>Community</td></tr>
</table>

The strategic objectives of our programmes align both with national and regional directives and the areas of delivery trusts have agreed with the ICB. All provide a tight focus on patient centred delivery and the fulfilment of each trust's NHS planning commitments.

Quality is a critical thread running through each programme and as such, can be demonstrated throughout this annual plan.

Concurrent with transformation must be our continued ability to deliver care that is safe, effective and provides a positive patient experience. Crucially, health inequalities must be addressed, particularly within hard-to-reach communities.

To reflect and respond to our changing healthcare landscape and priorities, our programmes will continue to develop and evolve through 2026/27.

As with the CMPC Provider Strategy, we have and will continue to see success, by working collaboratively in these areas.

CMPC Programmes – an overview

CMPC Programme	Benefits across Cheshire and Merseyside
Efficiency at Scale	Leveraging scale, standardisation and collaboration to deliver measurable efficiencies and improved productivity across NHS corporate services, procurement, digital and medicines optimisation.
Diagnostics	Ensuring patients have access to safe, equitable, clinically effective, efficient, innovative, timely and sustainable diagnostic services, representing best value for money.
Elective Reform and Transformation	Optimising demand initiatives through the transformation of referral processes and outpatient services. Improving productivity and harnessing system-wide capacity for the delivery of high-performing elective healthcare.
Community	Improving productivity, efficiency and clinical outcomes of community services through collaboration, sharing of best practice and alignment with national and regional priorities, including the shift from hospital to community.

Image: University Hospitals of Liverpool Group

Image: Cheshire and Merseyside Provider Collaborative

Efficiency at Scale Programme Priorities

The Efficiency at Scale Programme is a system-wide initiative, with CMPC trusts coming together to address shared challenges and deliver improvements that cannot be achieved in isolation.

Through it, we use scale, standardisation and collaboration to:

- Reduce unwarranted variation
- Deliver measurable efficiencies
- Improve resilience and productivity
- Strengthen quality across corporate services, procurement, digital optimisation and medicines optimisation

Collectively, improvements brought by the programme reduce health inequalities and support the levelling-up of services across Cheshire and Merseyside, as well as strengthening the system's long-term financial sustainability.

Efficiency at Scale

Just a few of our achievements for Cheshire and Merseyside 2025/26

Forecasted **£14 million procurement In-Year Estimate savings**, equating to **£19 million Financial Year End savings**

Corporate services **cost growth held at 5%** (below national and North West levels)

Supporting **£20 million prescribing efficiency savings** across the system

Achieved **£10 million** high-cost drugs savings

Continued progress toward a single payroll model, **reducing in-house services from four to two**

Image: North Cheshire and Mersey NHS Foundation Trust

Efficiency at Scale Programme Plan 2026/27

This year, the Efficiency at Scale Programme Plan moves away from short-termism by balancing transactional in-year delivery with a strategic, medium-term approach.

This aligns both to national planning and the CMPC Provider Strategy, with a focus on scale, standardisation and collaboration.

In this way it will reduce duplication, streamline processes and improve productivity across the system. Through realising these benefits, we will support more consistent delivery across all trusts.

Key strategic objectives

> Corporate services

We plan to create simpler, more scalable and consistent support functions across the system by progressing a single payroll provider, aligning finance ledger processes, developing shared service models and establishing a robust procurement hub. These elements combined will reduce corporate services costs and improve service resilience.

> Purchase at scale

Through delivery of the £6 million system procurement workplan, optimisation of NHS Supply Chain routes and the development of an estates category workplan, activity will be consolidated, contracting approaches will be standardised and access to high-quality products will be improved.

Coupled together, our procurement hub model and purchase-at-scale workplan will enable co-ordinated procurement. Through this, we will improve equity of supply, ensuring patients receive the right products at the right time, whilst optimising the system's £1.2 billion addressable spend.

> Digital optimisation

Our digital optimisation initiative will strengthen system and service harmonisation during the Commissioning Support Unit transition, delivering non-pay efficiencies and introducing innovation through Ambient AI and Agentic AI proof-of-concepts.

In this way, we will enhance interoperability, smooth workflows and release staff time for direct patient care, supporting reduced waiting times, providing a better patient experience, and improving patient outcomes.

> Medicines optimisation

Through medicines optimisation, the delivery programme will continue to reduce unwarranted variation through high-cost drugs work, progress the Aseptic Full Business Case and deliver prescribing harmonisation and optimisation (£26 million efficiencies are forecasted) across key pathways and specialties.

This will improve medicines safety and support better, more consistent and equitable outcomes for patients, reducing avoidable harm and admissions and improving access to effective therapies.

Diagnostics Programme Priorities

CMPC's Diagnostics Programme is a collaboration across all NHS Cheshire and Merseyside organisations, incorporating Endoscopy, Imaging, Pathology, Community Diagnostics Centres and Physiological Science clinical networks.

With 95% of patients requiring access to a diagnostic test, the programme (which covers over 70 tests) is a critical enabler both for the region and its trusts' cancer, emergency, elective and primary care performance.

Our work binds us all together, so that we can collectively deliver improved performance, productivity, value for money, resilience and quality for all our patients.

Image: The Clatterbridge Cancer Centre NHS Foundation Trust

Diagnostics

Just a few of our achievements for Cheshire and Merseyside 2025/26

Throughout 2025/26, **Cheshire and Merseyside ranked in the top 4 ICBs** for waiting time performance, with **93.4% of patients receiving their test within 6 weeks**

Advanced Acceleration Technology was installed on **11 MRI scanners**, resulting in an **extra 5830 scans per year**

More than 3000 patients have experienced a shorter waiting time due to CMPC's mutual aid procedure, **saving over £1 million spend**

AI solutions are being tested in Echocardiography, to **deliver increased productivity**. Demand management work has **reduced inappropriate referrals by 40%**

Image: University Hospitals of Liverpool Group

All Chest X-Rays are now reviewed with AI, **allowing more abnormalities to be detected** and **shortening lung cancer pathways by 3 days**

Secured £46.8 million revenue to cover Community Diagnostics Centre activity, training for sonographers, implementation of a new Laboratory Information System and patient pathways for breathlessness and hearing loss

Diagnostics Programme Plan 2026/27

In 2026/27 we aim to deliver exceptional diagnostic services, supporting the left shift of care through improvement and transformation initiatives.

Our focus will be on four strategic objectives, all of which will have a substantial impact not solely on diagnostics, but the system as a whole.

Key strategic objectives

> Performance and productivity - delivering minimum patient waiting times

By implementing system-wide demand management, utilisation and productivity plans, along with mutual aid and technology solutions that reduce the time taken for tests, we will ensure that 96.6% of patients receive a test within 6 weeks.

We will reduce the time it takes for results to become available, by implementing digital pathology and completing the Digital Imaging system Cloud upgrade. We will also reduce transfers from Urgent Treatment Centres to Emergency Departments, by ensuring more on-the-day tests are available.

> Strategy and standardisation - meeting population needs

Through the introduction of single queue technology, we will enable patients to select the provider with the shortest waiting time, as well as ensuring that they go straight to test stage, rather than having an outpatient appointment first.

We will also produce optimum service models for Interventional Radiology, Genomics and Phlebotomy, to maximise system resilience, drive out inefficiency and unwarranted variation.

> Digital and innovation – enhancing patient and clinician experience

By implementing several unified single digital solutions, cutting edge technologies and AI options, we will reduce duplication, save time and detect more abnormalities.

> Cost reduction - delivering best value for money

Through the consolidation of services and by minimising waste, we will reduce spend on non-NHS sub-contracting and deliver reduced spend in pathology. Additionally, we will maximise utilisation of all sites, so that spend per clinic is optimised.

Elective Reform and Transformation Programme Priorities

The Elective Reform and Transformation Programme is a collaboration between CMPC's acute and specialist providers. It supports the delivery of NHS Operational Planning priorities and longer-term transformation aligned to the NHS 10 Year Health Plan.

Working closely with CMPC's providers and wider system partners, the programme enables 'at scale' opportunities, increasing productivity, tackling unwarranted variation and improving outcomes for patients.

Image: Mid Cheshire Hospitals NHS Foundation Trust

Elective Reform and Transformation

Just a few of our achievements for Cheshire and Merseyside 2025/26

Image: The Walton Centre NHS Foundation Trust

2.4% improvement in 18-week **Referral to Treatment** performance

Reduced patients waiting **52 weeks** or more by **39%**

Number of patients waiting 65 weeks or more **reduced by 93%**, from 1003 in April 2025 to 23 in February 2026

Helped secure NHS England capital investment of £5.1 million to improve theatres, clinical spaces and upgrade medical equipment, **delivering improved productivity**

Elective Reform and Transformation Programme Plan 2026/27

In 2026/27, the programme aims to deliver high-performing elective care and support the left shift of care, through the provision of improvement and transformation.

Key strategic objectives

Demand management

Through demand management we will optimise the referral pathway in line with national best practice guidance and the principles of 'left shift,' safely reducing unnecessary demand on acute services and delivering care closer to home.

The programme will continue to build on the NHS Advice and Guidance improvements 2025/26, to ensure it is available in ten high impact specialties via Single Points of Access by October 2026.

To support this, we will also work in partnership with the wider system to develop new and innovative referral pathways, enabled by digital solutions that support the left shift of care into a community setting and the right patient in the right place, first time.

This will include a focus on transforming outpatient services by developing virtual, asynchronous multi-disciplinary review processes that support 'straight to test pathways' and avoid the need for patients to attend traditional outpatient appointments.

Clinical and operational productivity improvement

This initiative will improve clinical and operational productivity through the development of productivity bundles across the elective pathway, using Model Hospital information, and the adoption of a system-wide productivity improvement programme. Both are designed to optimise use of workforce, clinical capacity and system resources.

A critical focus of this work will be to review and standardise clinic templates across high impact specialties, improve outpatient first to follow up ratios and increase capped theatre utilisation to 85%.

Referral to Treatment performance oversight

Focus on this area will provide leadership of Cheshire and Merseyside elective performance outputs, supporting the delivery of the national Referral to Treatment targets through oversight and system-wide support. Through this, we will reduce the risk of patients' health deteriorating whilst they wait, keeping them healthier for longer and reducing hospital admissions.

The CMPC programme team will continue to work closely with trusts and NHS England to support the delivery of Referral to Treatment performance targets, including reducing the Cheshire and Merseyside waiting list by 33,000 by the end of March 2027.

System capacity management

This workstream will optimise the use of system capacity to improve patient access and deliver high quality care, whilst ensuring the most effective use of resources for all CMPC trusts.

We will build on work completed during 2025/26 to improve the utilisation of elective hubs as system assets across Cheshire and Merseyside, through the development of a System Capacity Management Hub and a single, shared Patient Tracking List.

Community Programme Priorities

Our Community Programme brings together CMPC's community providers, enabling us to support each other by realising the benefits of shared practice and delivery at scale.

With a focus on urgent and planned community care, it provides effective alternatives to hospital based services, enabling people to remain safe and well in their own homes.

The programme directly links with the CMPC Provider Strategy by aligning community services to localities and ensuring equity of service provision. This is implemented through the methodologies set out in the NHSE Standardising Community Health Services Guidance 2025.

Critically, it addresses variation in commissioning and service delivery, identifying models of care that achieve the best outcomes in the most efficient way. These are then adopted at scale, ensuring high quality, sustainable services that deliver value for money and, vitally, the best healthcare for patients.

As one of the three shifts described in the NHS 10 Year Health Plan, the programme identifies opportunities to move activity 'from Hospital to Community.' This is done with a particular focus on urgent care and providing community-based alternatives for people with an acute health requirement, those that can be treated without the need for hospital attendance and or, admission.

Image: North Cheshire and Mersey NHS Foundation Trust

Community

Just a few of our achievements for Cheshire and Merseyside 2025/26

27% increase in patients seen by Urgent Community Response services

51% increase in Virtual Ward referrals

Introduction of a clinical assessment service for 999 ambulance calls

2% reduction in Category 3 ambulance conveyances

Identification of a **cost saving opportunity** for providers of over **£5.5 million**

Image: North Cheshire and Mersey NHS Foundation Trust

Community Programme Plan 2026/27

By working collaboratively to standardise and enhance the Community Services offer in Cheshire and Merseyside, we can keep more people safe and well in their own homes and reduce the demand for hospital-based care.

Together we will ensure that our patients consistently experience reliable, sustainable and safe access to the most appropriate services to meet their health and care needs.

The programme will focus on three key strategic objectives in 2026/27.

Key strategic objectives

Pre-hospital care

We will maximise the use of urgent community services as alternatives to emergency department attendance and ambulance conveyance. This will be supported by a clinical assessment service that enables rapid patient access to the most appropriate clinical team in the community.

Non-acute beds

This initiative will build on progress already made in delivering hospital-level care in community settings. It will include further development of the 430 Virtual Ward beds across Cheshire and Merseyside, as well as increased use of digital and remote monitoring technology. This workstream will improve access to community beds, increasing productivity and enhancing the system's ability to provide care in a non-acute setting.

Standardising Community Services

Focus on this important area will enable us to align services to national neighbourhood health priorities and NHSE requirements, mapping cost, activity, outcomes, workforce and commissioning arrangements. This will allow us to support consistency, resilience, and sustainability across the system.

Through better efficiency and productivity, we will improve equity of access to community services, reviewing the balance between resource use and outcomes, and delivering community capital plans, including digital infrastructure, point of care testing, and out of hospital clinical space.

NHS
Cheshire and Merseyside
Provider Collaborative

Image: Wirral University Teaching Hospital NHS Foundation Trust

Contact us

Whether you want to explore the idea of collaboration, discuss this plan further, or simply have a question, please contact us using the details below.

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NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

Date: 30th July 2026

Board Assurance Framework Q1 26/27 Update

Agenda Item No: ICB/07/30/26/11

Responsible Director: Ben Vinter, Executive Director of Corporate Affairs and Governance

Board Assurance Framework Q1 26/27 Update

1. Purpose of the Report

The purpose of this report is to present an update on the activity undertaken to update the Board Assurance Framework (BAF) in the first quarter of 2026/27.

2. Executive Summary

2.1 The ICB Board is responsible for agreeing the strategic objectives of the organisation and ensuring the delivery of the strategic objectives of the ICB. The board assurance framework (BAF) captures these objectives (as agreed by the Board) and the key risks to their delivery as identified through discussion with executives and non-executive members and ultimately agreed by the Board. The BAF facilitates Board visibility and assurance on elements impacting delivery and the effectiveness of the controls in place to manage the risks.

The ICB Risk Management Strategy sets out committee and sub-committee responsibilities for risk and assurance. Risks held on the ICB's Board Assurance Framework (BAF) are those which have the potential to impact on the delivery of the ICB's Strategic Objectives.

The BAF (**Appendix 2**) reflects the strategic priorities contained within the 'Ten Year Health Plan' and the Cheshire and Merseyside Health and Care Partnership Plan 'All Together Fairer' whilst maintaining focus on wider NHS reform and the transition of ICBs to 'strategic commissioners' by 2027. The principal risks within the BAF are aligned against each of the four ICB core purposes, specifically:

- Improve outcomes in population health
- Tackle health inequalities in outcomes, experiences and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development.

A summary table of BAF risks can be found in **Appendix 1**. Amendments and updates to content within the individual BAF risks are made in blue font.

3. Ask of the Committee and Recommendations

3.1 **The Board is asked to:**

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

3.1.2 **NOTE** the proposed change in risk description for BAF risk P15 (Sustainability) and increase in risk score

3.1.3 **CONSIDER** any further action required by the Board to improve the level of assurance provided, or any 'new' risks which may require inclusion on the BAF.

4. Reasons for Recommendations

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

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

4.2 Non-Executive Board members play a critical role in providing scrutiny, challenge, and an independent voice in support of robust and transparent decision-making and management of risk. Committee Chairs are responsible, with the risk owner and the support of committee members, for determining the level of assurance that can be provided to the Board in relation to risks assigned to the committee and overseeing the implementation of actions as agreed by the Committee.

5. Background

5.1 The establishment of effective risk management systems is vital to the successful management of the ICB (and local NHS system) and is recognised as being fundamental in ensuring good governance. The ICB Board needs to receive robust and independent assurances on the soundness and effectiveness of the systems and processes in place for meeting its objectives and delivering appropriate outcomes. The Board is supported through the work of the ICB committees in reviewing BAF risks and providing assurances on key controls. The principal risks identified for 2025-28 were approved for adoption by the Board in November 2025 and form the basis of the Board Assurance Framework reported quarterly to the Board.

5.2 Although the ICB will inevitably take risks to achieve its aims and deliver beneficial outcomes to patients, public and other stakeholders all risks identified will be taken in a considered and controlled manner, and the Board has

determined the level of exposure to risks which is acceptable in general, as set out in the organisation's risk appetite statement.

5.3 As a publicly accountable organisation, the ICB is required to evidence that its decision-making structure is aligned with a robust system of internal control and based on principles of good governance. This is underpinned by the proactive identification, assessment and mitigation of risks to the ICB's strategic objectives, priorities and core purposes. This process is central to providing the Board with assurances that all required activities are focussed on continued delivery whilst maintaining compliance with legislation and regulatory requirements.

6. Quarter 1 2026/27 BAF Update

6.1 There are currently eight strategic risks included in the C&M ICB Board Assurance Framework. Each strategic risk has been assigned to an Executive Director (Risk Lead) who will work with the Corporate Governance Team to review and update content and assess the current level of risk that the ICB may be exposed to.

6.2 Following review, a minor change is proposed to the risk description for **P15** (Sustainability), summarised in the table below:

P15 original description	P15 new description
If we do not proactively shape and support a sustainable provider landscape, especially as we commission at-scale, integrated neighbourhood and digital-first services there is a risk of service loss, fragmentation, or failure. This would compromise our ability to deliver the Model ICB Blueprint's vision for joined-up, efficient, and resilient care.	*If the ICB is unable to maintain a safe and sustainable health and care system (clinically, operationally and financially) due to insufficient integration, ineffective collaboration between partners, and increasing operational and productivity pressure on provider organisations. Then the ICB's ability to deliver on the ambitions outlined in our 5-year Clinical and Strategic Commissioning Plan and Population Health Management Plan becomes compromised.*

6.3 The revised risk description for P15 is considered as more reflective of the changing system environment and the ICB's future role as a strategic commissioner. The risk more accurately describes the context of system sustainability and conveys the ICB's responsibility to ensure that the Cheshire and Merseyside health and care system remains clinically, operationally and financially sustainable over the medium to long-term. This revised risk description also links quite significantly to population health and transformational change in terms of system resilience. Following review and the revision of the description, the risk score has subsequently increased from 12 (moderate) to 16 (high).

6.4 A minor amendment has also been made to the risk description for **P16** (Shift to Neighbourhood and Community Care). The revised description is not considered to represent a material change to the nature of the risk and,

therefore, the associated controls, assurances and actions remain largely unchanged. The amendment is highlighted in blue font within the table contained in **Appendix 1.**

6.5 The Board is asked to note that digital colleagues consider that there is a need to identify and describe two risks within the digital landscape - the current related broadly to the risk associated with a cyber-attack and resilience and the other related to digital infrastructure. The cyber-attack risk has been updated and refined on this basis, whilst the digital infrastructure risk is to be developed and drafted over the course of the summer and is scheduled to be presented to Audit Committee at the start of the September 2026 for review and consideration. If endorsed, this BAF risk is likely to appear in future iterations of the BAF.

7. Strategic Risks (Quarter 1 2026/27)

7.1. A summary of the quarter 1 2026/27 BAF position is provided in the table below:

ID	Risk Title	Inherent score	Current Score (Q1)	Previous Score (Mar 26)	Target Score 2026-27	Risk Appetite	Long Term Target Date
P4	Quality & Safety failures in commissioned services	25	20	20	20	Minimal	March 2028
P11	Digital and cyber resilience gaps	20	16	16	16	Open	March 2028
P12	Failure to reduce health inequalities and improve population health	20	15	15	15	Cautious to open	March 2028
P13	Inability to achieve financial sustainability and productivity	25	15	20	15	Minimal	March 2028
P14	Failure to recover access and performance standards	25	20	20	20	Cautious	March 2028
P15	Sustainable Integrated Care System	25	20	15	15	Cautious to open	March 2028
P16	Failure to deliver the shift to Neighbourhood and Community based care	20	15	15	15	Open	March 2028
P17	Workforce capacity, capability and morale	20	16	16	16	Open	March 2028

7.2 There have been two changes in the quarter 1 position:

- **P13** (Financial sustainability) – risk score has **reduced** from 20 to 15. Score reduced following review of the strength of current controls, scope and mitigation plans.
- **P15** (Sustainable Integrated Care System) – risk score has **increased** from 15 to 20. The consequence score was increased following the re-write of risk description and subsequent review of controls (within the context of the new description).

7.3 A summary of each principal risk and its associated high-level mitigation actions is provided in **Appendix 2** of this report. The summaries set out further detail on

each risk - including the risk assessment and scoring rationale, gap analysis, current controls and their effectiveness, and the proposed in-year and long-term target risk scores.

7.4 Whilst risk scores do remain high, all planned actions are on track, with none currently assessed as 'problematic'. As progress is made with implementing, strengthening and embedding controls, the levels of risk should reduce in-year (in line with projected 'in-year' target scores). Focus will then be maintained on delivery of plans to mitigate the risk to an 'acceptable' level and to meet the long-term target score projected for 2028.

8. Forward plan for the remainder of 2026/27

8.1 A schedule for updating risks for the remainder of 2026/27 has been agreed with Executive Leads to ensure a more structured, timely approach to the risk refresh cycle. Further development work will take place in quarter 2 of 2026/27 to further strengthen this process.

8.2 As part of this work, assurances and controls will be mapped against existing reporting arrangements, including those supporting the ICB's Single Improvement Plan. This will identify where current reporting already provides sufficient assurance on risk mitigation, helping to avoid duplication and maintain alignment with established business-as-usual processes.

Implications and Comments

9. Link to delivering on the ICB Strategic Objectives and the national ICB Core Purposes / Priorities

- **Improve population health outcomes**
- **Tackle health inequalities**
- **Enhancing Productivity and Value for Money**
- **Helping to support broader social and economic development within the local area**

9.1 Effective risk management, including the BAF, support the objectives and priorities of the ICB through the identification and effective mitigation of those principal risks which, if realised, will have the most significant impact on delivery.

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

10.1 The Annual Delivery Plan sets out linkages between each of the plan's focus areas and one or more of the BAF principal risks. Successful delivery of the relevant actions will support mitigation of these risks.

11. Link to meeting CQC ICS Themes and Quality Statements

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

11.1 The establishment of effective risk management systems is vital to the successful management of the ICB and local NHS system and is recognised as being fundamental in ensuring good governance.

12. Finance

12.1 With exception of the specific risks identified, there are no financial implications arising directly from the recommendations of the report.

13. Communication and Engagement

13.1 No patient and public engagement has been undertaken.

14. Equality, Diversity and Inclusion

14.1 There are no equality or health inequalities implications arising directly from the recommendations of the report.

15. Climate Change / Sustainability

15.1 No identified impacts.

16. Next Steps and Responsible Person to take forward

16.1 Following receipt by the ICB Board at its July 2026 meeting, the BAF will be reviewed by the Executive Team during the second quarter of 2026/26. An updated BAF reflecting the quarter 2 position will be presented to the November 2026 Board for consideration.

17. Officer contact details for more information

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18. Appendices

Appendix 1: Board Assurance Framework Summary Table (Q1 2026/27)
Appendix 2 – Cheshire & Merseyside ICB Boad Assurance Framework (Q1 2026/27)

NHS
Cheshire and Merseyside

Appendix 1 – C&M ICB Board Assurance Framework Summary Table (Q1 2026/27)

ICB Core Purpose	BAF ID	Strategic risk	Risk Appetite (draft)	Current score	Previous Score	(proposed) Target Score	Lead director(s) / board lead	Lead committee / board
Improve outcomes in population health	P4	**Quality & Safety failures in commissioned services:** There is a risk that commissioned services will not consistently deliver high-quality, safe, and equitable care, undermining our statutory duty to improve population health and reduce inequalities. This risk is heightened as we shift resources from hospital to community and redesign care pathways to deliver the 10-Year Plan's ambitions for neighbourhood health, digital enablement, and prevention.	Minimal	20	20	10	Executive Clinical Director	Quality & Performance Committee
	P11	**Digital and Cyber Resilience Gaps:** Failure to ensure robust digital infrastructure, data sharing, and cyber security across the system could disrupt care, undermine public trust, and impede delivery of the "analogue to digital" shift. This would threaten our ability to deliver on the 10-Year Plan's requirements for a digitally enabled, data-driven, and patient-empowered NHS.	Open	16	16	8	Chief Digital Information Officer	Executive Committee / Audit Committee
Tackle inequalities in outcomes, experience and access	P12	**Failure to reduce health inequalities and improve population health:** Risk that ICB will not deliver measurable reductions in health inequalities or improvements in population health outcomes, particularly for the most deprived and vulnerable groups, if resources, commissioning, and partnership actions are not sufficiently targeted and aligned with All Together Fairer, Core20PLUS5, and the prevention and equity ambitions of the 10-Year Plan.	Cautious to open	15	15	10	Executive Director of Health and Integrated Care Commissioning	Executive Committee
Enhance productivity and value for money	P13	**Inability to achieve financial sustainability and productivity:** risk that the ICB and system partners will not achieve required financial savings, productivity gains, and operational cost reductions, as mandated by the Model ICB Blueprint and the 10-Year Plan. This could limit our ability to invest in prevention, neighbourhood health, and digital transformation, and may result in failure to meet statutory financial duties.	Minimal	15	20	10	Executive Director of Strategy & transformation	Finance, Investment and Contracting Committee
	P14	**Failure to Recover Access and Performance Standards:** There is a risk that the ICB will not effectively commission services and new pathways of care to deliver on the national standards for access and performance as set out in 2026/27 operational plans. This would undermine public confidence, exacerbate inequalities, and undermine delivery of the 10-Year Plan's commitment to timely, accessible care closer to home.	Cautious	20	20	10	Executive Director of Strategy and Transformation	Quality & Performance Committee
	P15	**Sustainable Integrated Care System:** The ICB is unable to maintain a safe and sustainable health and care system (clinically, operationally and financially) due to insufficient integration, ineffective collaboration between partners, and increasing operational and productivity pressure on provider organisations. Such a position compromises the ICB's ability to deliver on the ambitions outlined in our 5-year Clinical and Strategic Commissioning Plan and Population Health Management Plan.	Cautious to open	20	15	8	Executive Clinical Director	Executive Committee
Help the NHS support broader social and economic development	P16	**Failure to Deliver the Shift to Neighbourhood and Community-Based Care:** There is a risk that the ICB will not achieve the required shift from hospital-centric to neighbourhood and community-based models of care, as set out in the 10-Year Plan and Model ICB Blueprint, due to insufficient scope for investment, investment follow through, workforce capability, or provider collaboration. Such a situation would undermine prevention, integration, and local access ambitions	Open	15	15	10	Executive Director of Health and Integrated Care Commissioning	Executive Committee
	P17	**Workforce Capacity, Capability, and Morale:** The scale and pace of organisational redesign, including significant headcount reductions and new ways of working, may disrupt strategic commissioning functions, destabilise workforce morale, and impede delivery of transformation priorities. This threatens our ability to build the skills and capabilities needed for the Model ICB and to deliver the 10-Year Plan's workforce and leadership ambitions.	Open	16	16	8	Chief Executive / Chief People Officer	Executive Committee

APPENDIX 2

BOARD ASSUANCE FRAMEWORK

NHS Cheshire & Merseyside ICB Board Assurance Framework 2025-2028

Risk Title	**Quality and safety failures in commissioned services**
Strategic Risk Ref	**P4**
Risk Description	There is a risk that commissioned services will not consistently deliver high-quality, safe, and equitable care, undermining our statutory duty to improve population health and reduce inequalities. This risk is heightened as we shift resources from hospital to community and redesign care pathways to deliver the 10-Year Plan's ambitions for neighbourhood health, digital enablement, and prevention.
ICB Core Purpose	Improve population health outcomes
ICB Strategic Goal	Reduce health inequalities
Directorate	Quality & Performance
Lead Director	Executive Clinical Director
Lead Committee	Quality & Performance Committee
Risk Appetite	Minimal

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target Score	Long Term Target Date
Likelihood	5	4				4	2	March 2028
Impact	5	5				5	5	
Risk Level	25	20				20	10	

Number of Linked Risks on Corporate Risk Register

Low (1 – 4)	Mod (6 – 12)	High (15 – 25)

Lines of Defence	Sources of Assurance Level	Assurance Level
1st Line	System Oversight Groups (Special Educational Needs & Disabilities, Safeguarding, Quality, Individual Assessment and Commissioning, LMNS Assurance Board) Quality Impact Assessment assurance reporting to Quality & Performance Committee	Acceptable
2nd Line	Quality & Performance Committee - reporting to ICB Board; Regional Quality Group reporting.	Acceptable
3rd Line	Quality Leadership & Board - Assurance meetings with NHSE; Internal Audit reports & assurance	Acceptable

Rationale for Risk Score and Progress made in the quarter

The increased focus on the challenging system financial position, availability of resources and our need to increase productivity in 2026-27 makes it imperative to mitigate any potential impact to the quality and safety of commissioned services. It is therefore anticipated that progress in further reducing this risk will be limited during the current financial year. There remains the potential for multiple deaths, permanent injuries or irreversible health effects, or harm to more than 50 people; totally unacceptable quality of clinical care, and gross failure to meet national standards. Good progress has been made in establishing the quality oversight framework providing a firm foundation for identifying emerging concerns and appropriate intervention.

Key Controls

1. Well established provider oversight processes / Quality Performance Dashboard
2. Quality Assurance Framework established and aligned with National Quality Board Standards
3. Quality Impact Assessment process established and embedded in ICB decision-making processes
4. Provider Quality Schedules within NHS Contract / standardised C&M Quality Schedule
5. Process to evolve assurance and oversight of providers to include reporting and discussion at Quality System Oversight Group. Initial Quality SOG to take place from July 2026.
6. Rapid Quality Reviews, Independent Investigations & other reviews and responses to local and national enquiries and investigations

Gaps in Control or Assurance

1. Implementation of Quality schedules for 2026/27
2. Systematic triangulation of quality indicators to improve intelligence
3. Insufficient mechanisms to systematically collect, analyse, triangulate and escalate patient feedback
4. Gaps in assurance could increase whilst ICB structures are in transition (potential disruption to maintaining compliance of QA processes relating to safeguarding, Individual Assessment and Commissioning (IAC) and SEND).
5. Reduction in workforce capability and capacity due to organisational changes and organisational vacancies increases risk of gaps across central and locality functions

Action

No	Action Required	Due Date	Update On Actions	Progress
1.	Development of Quality Schedule to support 2026/27 Commissioning Intentions	Mar 26	Quality schedules are embedded within Trust contracts, with 26/27 contracts still being finalised. Monitoring takes place through routine Quality/Contract meetings.	On track
2.	Enhance a quality intelligence approach through developing capability and processes. This will enable systematic triangulation of quality, safety, performance, patient experience, clinical effectiveness and financial intelligence, supporting the early identification of risks and timely commissioning interventions.	Q3 26/27	Strategy is being developed. ICB Management of Change process ongoing.	On track
3.	Strengthen use of patient experience, insight and feedback to ensure the early identification of negative impact on patient experience	Ongoing	Proposal is being generated through the System Quality Governance Team for presentation to Q & P Committee in September 2026. This will include exploring opportunities to work with external partners.	On track
4.	Ensure ICB governance structure redesign aligns with statutory requirements and supports delivery	Ongoing	New operating model to be implemented Q3 26/27 - governance will be realigned to support delivery in the new structure.	On track
5.	Ensure Clinical Quality Directorate staffing structure provides adequate capacity and capability to address workforce gaps.	Q3 26/27	Phase 3 of Management of Change to conclude autumn 2026.	On track

Date of update: Jul 2026

Next update due: Sept 2026

NHS Cheshire & Merseyside ICB Board Assurance Framework 2025-2028

Risk Title	**Digital & Cyber Resilience Gaps**
Strategic Risk Ref	**P11**
Risk Description	Failure to ensure robust digital infrastructure, data sharing, and cyber security across the system could disrupt care, undermine public trust, and impede delivery of the "analogue to digital" shift. This would threaten our ability to deliver on the 10-Year Plan's requirements for a digitally enabled, data-driven, and patient-empowered NHS.
ICB Core Purpose	Improve population health outcomes
ICB Strategic Goal	Accelerate to digital innovation
Directorate	Clinical Directorate
Lead Director	Chief Digital Information Officer
Lead Committee	Audit Committee
Risk Appetite	Open

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target Score	Long Term Target Date
Likelihood	5	4				4	2	March 2028
Impact	4	4				4	4	
Risk Level	20	16				16	8	

Number of Linked Risks on Corporate Risk Register: Low (1 – 4) | Mod (6 – 12) | High (15 – 25)

Rationale for Risk Score and Progress made in the quarter

The possibility of a cyber-attack cannot be completely removed, and a residual risk will remain, but the implementation of the 5-Year Cheshire and Merseyside Cyber Security Strategy aims to mitigate the level of risk that the ICB is exposed to over the lifetime of the strategy. Potential for patient harm, major effect on quality of clinical care, significant financial loss, significant loss of trust and confidence of stakeholders and adverse national media. Limited investments expected in 2025-26 will maintain the risk at the current level. In-year funding (secured through National Cyber Resilience Fund) will fund the delivery of priorities in the programme. A further round of funding is expected in 2026/27 with this year's programme aiming to build the business case to secure further funding. Issues in relation to cyber security manager vacancy mitigated via our IT providers.

Key Controls

1. C&M ICB Cyber Security Strategy
2. Cyber incident / Business Continuity Plan
3. ICB monitoring of system-wide cyber security standards
4. Digital Services Delivery Board (ICB infrastructure only)
5. Digital and Data Strategy Management group (system wide overview) – Cyber Management group reporting into this
6. Incident management and support in major incidents formally agreed with ICB providers
7. IT provider contracts and formal data sharing agreements
8. Agreement in place for the implementation of approach
9. Plans in place to conduct Board Awareness session on Cyber Security

Gaps in Control or Assurance

1. ICS / ICB Capacity and investment to respond to continuously evolving threat – funding streams delayed by a year with consequent impact on control action timescales. Non recurrent funding has now been received from NHSE. Bids submitted for future years funding up to 2030.
2. Gaps in ICB cyber leadership (Head of Cyber Security) and out of hours response capacity.
3. Lack of organisational & system level monitoring and reporting of standards, compliance & risks.
4. Lack of robust consistent approach to the incorporation of Cyber security standards into procurement and contract management processes across all organisations in the ICB.
5. Lack of robust workforce plan for staff with cyber security skills across the system
6. Lack of robust workforce plan for staff with cyber security skills across the system.

Lines of Defence	Sources of Assurance Level	Assurance Level
1st Line	Cyber security updates provided to ICB Audit Committee (quarterly)	Acceptable
2nd Line	Formal cyber risk reporting to ICB Board	Acceptable
3rd Line	1. Regular Regional and National communication with NHSE and other NHS organisations 2. Annual Data Security Protection Toolkit (DSPT) submission (reviewed by NHSE Non recurrent national funding received to address priority risk areas	Acceptable

Action

No	Action Required	Due Date	Update On Actions	Progress
1.	Plan for expenditure of non-recurrent funding to address priority risk areas across the system including an approach to managing out of hours response by pooling existing resource.	Mar 27	Provider CIO appointed to lead on Cyber programme across the system. Work has commenced on developing these plans	On track
2.	Plan to implement a consistent approach to report standards, compliance and risks at both organisation and system level.	Mar 27	Agreement in place with Governance leads and Audit Committee chairs. Development of implementation plan now underway	On track
3.	Explore opportunity to standardise cyber tooling across C&M and procure at scale	Mar 27	Work underway to carry out baseline assessment of current cyber tooling and agree plan to transition to a standardised solution procured at scale.	On track
4.	Analyse / map critical service/supply chain security assurances and gaps across C&M organisations. Identify significant exposure points and develop reporting	Mar 27	Work to commence in Q3.	Not started
5.	Create standard security and assurance procurement & contracts requirements to be shared across all organisations across ICB (6	Mar 27	Work to commence in Q3	Not started
6.	Undertake a skills survey across Digital teams within the ICS, analysing data to identify gaps in organisations and across the footprint and build out a training needs assessment based upon the outcomes.	Mar 27	Work to commence in Q3	Not started

Date of update: Jul 2026

Date next update due: Sept 2026

NHS Cheshire & Merseyside ICB Board Assurance Framework 2025-2028

Risk Title	**Failure to reduce health inequalities and improve population health**
Strategic Risk Ref	P12
Risk Description	There is a risk that C&M ICB will fail to deliver measurable reductions in health inequalities or improvements in population health outcomes, particularly for the most deprived and vulnerable groups, if resources, commissioning, and partnership actions are not sufficiently targeted and aligned with All Together Fairer, Core20PLUS5, and the prevention and equity ambitions of the 10-Year Plan. If the ICB does not embed prevention and fails to address the wider determinants (eg. housing, employment, environment) through commissioning and system leadership, it will limit our impact on long-term health outcomes and economic prosperity.
ICB Core Purpose	Tackle health inequalities in outcomes, experience and access
ICB Strategic Goal	Improve outcomes in population health and healthcare
Directorate	Integrated Care & Commissioning
Lead Director	Executive Director of Integrated Care & Commissioning
Lead Committee	ICB Executive Committee
Risk Appetite	Cautious-open

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target Score	Long Term Target Date
Likelihood	4	3				3	2	March 2028
Impact	5	5				5	5	
Risk Level	20	15				15	10	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4) | Mod (6 – 12) | High (15 – 25)

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	Progress reports to C&M HCP Board on delivery & implementation of programmes and projects; Alignment with new ICB governance review will be required in response to NHS 10 Year Plan and future of ICPs which for our HCP is currently in abeyance.	Acceptable
2nd Line	Population Health Partnership reporting to the C&M ICB Executive Committee. Health Inequalities 'Stock Take' for NHSE reported to Population Health Partnership Group & Reporting to ICB Board will continue on priority prevention areas and also be captured through wider Neighbourhood Health Delivery Programmes (BAF risk P16)/	Acceptable
3rd Line	NHS Oversight Metrics reporting Domain 1 – Population health, prevention and reducing inequality. Core20+5 Health Inequalities Stock take for NHSE reported to Population Health Partnership Group, C&M HCP Board and NW NHSE Director of Public Health.	Acceptable

Rationale for Risk Score and Progress made in the quarter

There is a significant risk the ICB will fail to deliver a range of strategic priorities such as the C&M Joint Forward Plan and the All Together Fairer: Our Health and Care Partnership Plan. he failure to deliver these strategic priorities will cause major reductions in health outcomes and life expectancy, alongside a widening of the health inequality gap for people living in deprived areas or who are socially excluded (Impact score: 5). While current controls are effective in reducing the likelihood of this risk materialising, it remains a possibility (Likelihood score: 3).

Key Controls

1. Population Health Management (PHM) Framework
2. Joint Strategic Needs Assessments (JSNAs) of current and future needs of local populations
3. Agreed system-wide priorities for improving population health and reducing health inequalities
4. CORE20+5 approach to identify and target populations
5. Targeted resource allocation with focus on populations with poorest outcomes
6. Health Inequalities Impact Assessment process for commissioning decisions.

Gaps in Control or Assurance

1. Reduced investment in Health Inequalities and Prevention funding allocation has led to delivery being curtailed and opportunities to demonstrate impact.
2. Integrated Neighbourhood Teams do not consistently utilise shared population health intelligence to inform decision-making, resource allocation and care coordination.
3. HCP is currently in Abeyance until a new model of governance is agreed with both Combined Authorities and local partners.
4. Arrangements for the safe and effective transfer of Section 7A commissioning responsibilities are not fully established.

Action

No	Action Required	Due Date	Update on Actions	Progress
1.	Continue to take a Population Health approach to targeted action on the three leading causes of the gap in Healthy Life Expectancy (CVD, Respiratory and Cancer)	Mar 27	ICB named as a 'Prevention Accelerator' site for CVD prevention with LCR Combined Authority. Together Smokefree Programme continues to drive improvements in respiratory health inequalities. Targeted Lung Health Check Programme now being expanded across Cheshire and Merseyside.	On track
2.	Integration of Population Health Management within Integrated Neighbourhood Teams	Dec 26	Liverpool Place is achieving NHS excellence award for use of PHM in proactive care, and neighbourhood health, demonstrating further examples of PHM being embedded into practice. This needs to be 'systematised' as part of new operating model and Neighbourhood health teams across the ICB.	On track
3.	Population Health Partnership reporting lines to be confirmed (linked to approval of revised ICB governance arrangements / HCP)	Oct 26	Reporting to Executive Committee. Collaborative discussions continue to evolve with partners in response to the Ten-Year health Plan and future requirements of working with our local Councils and Combined Authorities.	On track
4.	Manage the transfer of Section 7a roles and responsibilities from NHSE to the ICB	Mar 27	Office for Pan Integrated Commissioning will be established for regions across the country. This will include core services of screening and immunisation, Health and Justice services and specialised commissioning.	On track

Date of update: July 2026

Date next update due: Sept 2026

NHS Cheshire & Merseyside ICB Board Assurance Framework 2025-2028

Risk Title	**Inability to achieve financial sustainability and productivity**
Strategic Risk Ref	**P13**
Risk Description	Risk that the ICB will not achieve required financial savings, productivity gains, and operational cost reductions. This could limit our ability to invest in prevention, neighbourhood health, and digital transformation, and may result in failure to meet statutory financial duties.
ICB Core Purpose	Enhance productivity and value for money
ICB Strategic Goal	Deliver financial stability
Directorate	Finance & Contracting
Lead Director	Executive Director of Finance & Contracting
Lead Committee	Finance, Investment and Contracting Committee
Risk Appetite	Minimal

Risk Scoring and Tolerance 2026/27

	Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target Score	Long Term Target Date
Likelihood	5	3				3	2	March 2028
Impact	5	5				5	5	
Risk Level	25	15				15	10	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4) | Mod (6 – 12) | High (15 – 25)

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	Regular financial performance reports provided to Finance, Investment & Contracting Committee (FICC) reflecting ICB financial performance (monthly)	Acceptable
2nd Line	Formal update on ICB/ICS financial performance presented to ICB Board as standing agenda item (presented by Executive Director of Finance)	Acceptable
3rd Line	Review of provider cash position & BPPC performance by National Team	Acceptable

Rationale for Risk Score and Progress made in the quarter

There is potential for a major financial loss, special measures and significant impact on trust and confidence of stakeholders (impact 5). The scale of the financial gap means that the likelihood is currently possible (3). Planned actions to secure ICS wide agreement and NHSE approval to a Medium-Term Financial Strategy are in progress. It is anticipated that will reduce the likelihood to possible (3) achieving the target risk score of 15 by year end. The longer-term aim is to reduce to a moderate level over the lifetime of the medium-term financial strategy.

Key Controls

1. Revised SORD and OSORD to ensure grip on authorised sign-off of expenditure
2. Revised Finance committee structure to prioritise financial recovery and strategic focus on financial risk
3. FICC responsible for oversight / assurance of ICB and provider efficiency programmes (grip and control meetings)
4. Procurement Decision Review Group acts as formal sub-group of FICC – acts as approved procurement route
5. Single Improvement Plan (SIP) agreed actions and monitoring of delivery of improvement actions
6. NHS Oversight Framework (NOF) criteria & guidance

Gaps in Control or Assurance

1. Medium-term financial plan
2. Strengthened organizational structures for finance, contracting and procurement functions
3. Standardisation of formal processes for management/oversight of contracts
4. Identify CRES/CIP savings targets for each year (over 3 year period)
5. Sufficient oversight, forecasting and demand management to prevent activity growth exceeding planned levels (commissioning strategy & plan)

Action

No	Action Required	Due Date	Update on Actions	Progress
1.	Develop the 2026/27 financial plan	Mar 2026	Agreed 26/27 contracts	Completed
2.	Implementation of Financial Governance review to further increase grip & control	Ongoing	Developed in line with Single Improvement Plan	On track
3.	Implementation of robust contracting and contract management arrangements	July 2026	Revised reporting arrangements to FIC Committee from July 26	On track
4.	Enhanced Programme Management approach to delivery of CRES programmes (including All Age Continuing Care and Prescribing). Regular deep dives in FICC.	Ongoing	Agreed 26/27 plan	On track
5.	Identify 'Left Shift' costs / implement allocation	Ongoing	Allocate 'left shift' resource over 3 years	On Track

Date of update: July 2026

Date next update due: Sept 2026

NHS Cheshire & Merseyside ICB Board Assurance Framework 2025-2028

Risk Title	**Failure to recover access and performance standards**
Strategic Risk Ref	**P14**
Risk Description	There is a risk that the ICB will not effectively commission services and new pathways of care to deliver on the national standards for access and performance as set out in 2026/27 operational plans. This would undermine public confidence, exacerbate inequalities, and undermine delivery of the 10-Year Plan's commitment to timely, accessible care closer to home.
ICB Core Purpose	Enhance productivity and value for money
ICB Strategic Goal	Improve planned and elective care
Directorate	Strategy & Transformation
Lead Director	Executive Director of Strategy & Transformation
Lead Committee	Quality & Performance Committee
Risk Appetite	Cautious

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target Score	Long Term Target Date
Likelihood	5	4				4	2	March 2028
Impact	5	5				5	5	
Risk Level	25	20				20	10	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4) | Mod (6 – 12) | High (15 – 25)

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	1. Contract management processes (e.g. CQPM meetings) 2. Performance Report received by Quality & Performance Committee as standing agenda item	Acceptable
2nd Line	1. Q&P Committee reporting to ICB Board 2. Oversight via NHS Oversight Framework - identification of emerging concerns	Acceptable
3rd Line	1. NHSE 'Tiering' regime for UEC, Cancer, Elective & Diagnostics 2. NHSE oversight via NHS Oversight Framework 3. NHSE Programme Boards and groups for UEC, Elective, MH, Primary Care	Acceptable

Rationale for Risk Score and Progress made in the quarter

National standards cover a wide range of areas across acute hospitals, mental health and community settings and primary care. The likelihood of one or more not being achieved is high. Potential impact is inherently high, particularly for access to urgent and emergency care and cancer services. In terms of progress this quarter, performance against access standards for cancer and diagnostics remains strong, whilst the most significant challenges remain in UEC and elective as per the IPR. Likelihood high due to scale, complexity and fragility of the C&M system, and significant ongoing system-wide operational and financial challenges. Formal intervention by NHS England ongoing, with undertakings in place. Existing controls are partially effective but not yet sufficient to reduce likelihood.

Key Controls

1. System Elective Recovery Dashboard / tracking of all performance, activity and operational planning objectives and/constitutional standards. Mutual aid in place for elective, cancer and diagnostic care.
2. Agreed indicative activity plans within provider contracts and approved through formal governance.
3. BI activity models to support RTT funded activity
4. C&M ICB System Coordination Centre (SCC) oversees system operational activities, pressures and escalation.
5. C&M Provider Collaborative Elective Reform & Transformation Plan - delivery via C&M Provider Collaborative
6. All providers have submitted RTT Delivery Plans aligned to the 'high impact' areas; 65wk Performance and Delivery Group in place to oversee 65wk recovery plan.
7. Performance & Delivery Meetings with individual providers (formally PTLs) focused on the 2026/27 metrics

Gaps in Control or Assurance

1. Commissioning intentions require further development for the remainer of the medium-term planning cycle.
2. Refreshed contracting and performance framework required with clear KPIs and escalation routes & financial and activity reconciliation processes to reflect new structures and operating model.
3. Lack of SPoA, intermediate tier and 'Diagnose to Refer' models for planned care to enable OP reduction in demand IS market and contract management creating disruption to commissioned activity and pathways
4. ED demand, NCTR numbers and lost bed days not sufficiently impacted by transformation of pathways/services/BCF investments to reduce demand/improve flow
5. Develop SPoA, intermediate tier services and new 'diagnose to refer' pathways for planned care

Action

No	Action Required	Due Date	Update on Actions	Progress
1.	Development of 2026/27 Commissioning Intentions for sharing with system.	Sept 26	Commissioning intentions remain under development with some incentive schemes proposed	On Track
2.	Establishment of 26/27 oversight, performance and contract review meetings with financial and activity reconciliation processes	May 26	Framework drafted, aligned with Regional oversight. First meetings August 26	On Track
3.	Refreshed Integrated Performance Report and approach to performance management to reflect new staffing structures and operating model	Sept 26	New reports drafted for Board and sub committees	On Track
4.	Develop system UEC strategy and plans and ensure VFM from pooled budgets/BCF	Oct 26	UEC strategy developed and programme arrangements in place. BCF pooled budget reviews ongoing. Frailty programme to be finalised	On Track
5.	System workshop to develop shared commitment	Mar 27	Draft BC for new model of care	On Track

Date of update: Jul 2026

Date next update due: Sept 2026

NHS Cheshire & Merseyside ICB Board Assurance Framework 2025-2028

Risk Title	**Sustainable integrated care system**
Strategic Risk Ref	**P15**
Risk Description	If the ICB is unable to maintain a safe and sustainable health and care system (clinically, operationally and financially) due to insufficient integration, ineffective collaboration between partners, and increasing operational and productivity pressure on provider organisations. Then the ICB's ability to deliver on the ambitions outlined in our 5-year Clinical and Strategic Commissioning Plan and Population Health Management Plan becomes compromised.
ICB Core Purpose	Enhance productivity and value for money
ICB Strategic Goal	Strategic system leadership
Directorate	Strategy & Transformation
Lead Director	Executive Director Strategy & Transformation
Lead Committee	Executive Committee
Risk Appetite	Cautious-open

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target Score	Long Term Target Date
Likelihood	5	4				3	2	March 2028
Impact	5	5				5	5	
Risk Level	25	20				15	10	

Number of Linked Risks on Corporate Risk Register

Low (1 – 4)	Mod (6 – 12)	High (15 – 25)

Rationale for Risk Score and Progress made in the quarter

There is potential for major effect on quality of clinical care and non-compliance with national standards posing significant risk to patients, and significant impact on trust and confidence of stakeholders (impact 5). Current controls are maintaining the likelihood at likely (3). Strategic transformation programmes have been established (or sponsored with partners) to address service sustainability issues and work will continue to develop case for change and consultation proposals during 2025-26 but are not expected to be complete or impact on the risk level until 2026-27 and beyond. Progress has been made on key programs over the last quarter.

Key Controls

1. C&M Clinical Transformation Programmes include Liverpool Clinical Services Review, Liverpool Women's, Sefton 'Shaping Care Together', East Cheshire task force
2. C&M Provider Collaboration (CMPC) core community offer and 'baselining' supporting alignment of in-hospital and out-of-hospital services supporting 'left shift' to n'hood and community healthcare
3. CMPC Blueprint priorities which identify development opportunities for service chains / sector collaboration in paediatrics, MH and LD, cancer and neurology, sub-regional pathway design
4. Complex and high-risk maternity and gynaecology care in Liverpool, C&M Maternity Services Review and Regional Maternity & Neonatal review
5. C&M Neighbourhood Framework/N'hood Health Leadership
6. Mutual aid arrangements in place across C&M and CMPC focus on priority areas for service fragility

Gaps in Control or Assurance

1. Continued dependence on non-recurrent deficit support funding and financial top-up payments without agreed exit plan
2. Lack of maturity of integrated governance arrangements/new contract models between Provider Collaborative, partners and the ICB governance structures
3. Limited system agreement/oversight on the mechanisms to transact benefits realisation from improvement initiatives
4. Understanding of the impact of ICB organisational reform on provider oversight and transformational capacity & capability is not matured

Lines of Defence	Sources of Assurance Level	Assurance Level
1st Line	Provider/ICB Joint Committees ICB Executive Committee	Acceptable
2nd Line	ICB Board oversight	Acceptable
3rd Line	NHS C&M is part of regional and national NHSE oversight / assurance of delivery of improvement and transformation programmes	Acceptable

Action

No	Action Required	Due Date	Update On Actions	Progress
1.	Agree multi-year tapering to exit financial support arrangements to provider organisations. Commence exercise for community & mental health services in line with NHS guidance/timetable	Q4 26/27	First draft reviewed at FICC. Application of 'deconstructing the block' guidance to acute care underway.	On track
2. 3.	Align ICB's revised governance arrangements with those of the Provider Collaborative governance to provide clarity on decision-making and oversight of improvement programmes.	Q3 26/27	ICB's governance review will ensure alignment with Provider Collaborative governance to provide clarity on decision-making and oversight of improvement programmes – as appropriate. CMPC are currently approaching these issues on a per theme basis. This ICB is working alongside partners on these discreet areas of work	On track
4.	Continue to work with Provider Collaborative and other partners to agree routes to IHO and other contractual models to support integrated care delivery and strategic commissioning in localities.	Q4 26/27	Support for wave 1&2 AfT. Contractual models for multi-provider partnerships under review	On track
5. 6.	Ensure the ICB has the right capacity in new structure to fulfil its responsibilities in relation to provider oversight and delivery of system transformation.	Q3 26/27	Priority programmes within Change Portfolio in draft for 1st exec review end July	On track

Date of update: Jul 2026

Date next update due: Sept 2026

NHS Cheshire & Merseyside ICB Board Assurance Framework 2025-2028

Risk Title	**Failure to Deliver the Shift to Neighbourhood and Community-Based Care**
Strategic Risk Ref	**P16**
Risk Description	There is a risk that the ICB will not achieve the required shift from hospital-centric to neighbourhood and community-based models of care, as set out in the 10-Year Plan and Model ICB Blueprint, due to insufficient scope for investment, investment follow through, workforce capability, or provider collaboration. Such a situation would undermine prevention, integration, and local access ambitions
ICB Core Purpose	Support broader social and economic development within the local area
ICB Strategic Goal	Implement integrated neighbourhood teams
Directorate	Health and Integrated Commissioning
Lead Director	Executive Director - Health and Integrated Commissioning
Lead Committee	ICB Executive Committee
Risk Appetite	Open

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target Score	Long Term Target Date
Likelihood	4	3				3	2	March 2028
Impact	5	5				5	5	
Risk Level	20	15				15	10	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4) | Mod (6 – 12) | High (15 – 25)

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	Reporting to Population Health Board and NbH Programme Board, to Strategic Commissioning Group, ICB Executive Committee who provide oversight of work programmes and consider alignment	Acceptable
2nd Line	Reporting to ICB Board on delivery and implementation of programme and associated projects	Acceptable
3rd Line	Core20+5 Health Inequalities 'stock take' for NHSE reported to Population Health Partnership Board a, C&M HCP Board (or successor), NHSE North West Director of Public Health and delivery of NbH Health metrics per government guidance	Acceptable

Rationale for Risk Score and Progress made in the quarter

There is a significant risk that the ICB will fail to deliver with partners a range of strategic priorities such as the C&M 5 Year Clinical and Strategic Commissioning Plan, NHS Delivery Plan and 'All Together Fairer: Our Health and Care Partnership Plan. Failing to deliver these strategic priorities, navigating the partnership and cultivating the trust, collaboration and ambition across sectors required to define, enact and sustain these ambitions could widen the health inequality gap for all but especially those living in deprived areas or those who are socially excluded. Although current controls are effective in reducing the likelihood of the risk materialising, it remains a possibility.

Key Controls

1. C&M Clinical and Strategic Commissioning Plan 2026-2031 sets out ambitions for transition from current operating model to strategic commissioner role
2. Data into Action - use of evidence and data platforms for risk segmentation and risk stratification
3. NbH Infrastructure investment priorities
4. Integrated Neighbourhood Teams: Maturity Matrix
5. Recruitment to Neighbourhood team leadership structure (June 2026)
6. Establishment of ICB Strategic Commissioning Group and alignment with refreshed NbH Board
7. Health inequalities funding (including SDF) secured for 2026/27
8. Joint Health, and Wellbeing Strategies with C&M Local Authorities and central role of HWBB in NbHs
9. NHS Trust contracts (including contract schedule to support reducing health inequalities)

Gaps in Control or Assurance

1. Development and maturity of 58 C&M neighbourhoods for readiness of anticipated new national contracting models for 2027/28
2. Metrics and maturity matrix to be agreed & systems/processes needed to measure progress
3. Commissioning intentions for 2026/27 to be drafted and approved by ICB Board with appropriate governance
4. Left Shift funding allocations for 2026-2029 to be confirmed / phased / implemented
5. Role and opportunity of combined authorities

Action

No	Action Required	Due Date	Update on Actions	Progress
1.	Create ICS/Partnership N'hood Development Blueprint and model of care that delivers 'Left Shift' and improved outcomes for population	Dec 2026	Programme Director appointed June 2026 with supporting team to drive Blueprint	On Track
2.	Develop 'Left Shift' and community transformation programme to ensure investment to deliver national NH framework metrics	2026/7	Matrix working model to be implemented across ICB (finance, BI, Pop Health & Contracting) to ensure delivery	On Track
3.	Reset Neighbourhood Programme Board with new ToR and membership with oversight role and system outcomes	Sept 2026	Aiming to include expertise from primary care, NHS providers, local government and wider communities	On Track
4.	Enable development and maturity of 58 neighbourhoods across C&M to meet local needs & in readiness for new national contracting models for 27/28	Dec 2026	Healthwatch/new engagement framework developed. Links to health on the high street initiatives and pride of place funding	On Track
5.	Establish and embed in HbH working primary care collaborative	Dec 2026	Aiming to include expertise from primary care, NHS providers, local government and wider communities	On Track

Date of update: July 2026

Date next update due: Sept 2026

NHS Cheshire & Merseyside ICB Board Assurance Framework 2025-2028

Risk Title	**Workforce Capacity, Capability, and Morale**
Strategic Risk Ref	**P17**
Risk Description	The scale and pace of organisational redesign, including significant headcount reductions and new ways of working, may disrupt strategic commissioning functions, destabilise workforce morale, and impede delivery of transformation priorities. This threatens our ability to build the skills and capabilities needed for the Model ICB Blueprint and to deliver the 10-Year Plan's workforce and leadership ambitions.
ICB Core Purpose	Enhance productivity and value for money
ICB Strategic Goal	Support workforce resilience
Directorate	Chief Executive
Lead Director	Chief People Officer
Lead Committee	Executive Committee
Risk Appetite	Open

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target	Long Term Target Date
Likelihood	5	4				4	2	March 2028
Impact	4	4				4	4	
Risk Level	20	16				16	8	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4) | Mod (6 – 12) | High (15 – 25)

Lines of Defence	Sources of Assurance Level	Assurance Level
1st Line	Reporting of System Workforce Dashboard to ICB People Committee. Reporting to Executive Committee. Regional CPO Meeting	Acceptable
2nd Line	Reporting to ICB Board from Executive Committee NW Staff Partnership Forum	Acceptable
3rd Line	Internal Audit Plans; NHSE Assurance Mechanisms	Acceptable

Rationale for Risk Score and Progress made in the quarter

The current risk score reflects both existing and emerging factors relating to NHS Reform / Model ICB Blueprint and continued uncertainty of future workforce needs. C&M ICB has a number of challenges relating to ongoing workforce gaps, reduced staff wellbeing, lower morale and inequality of opportunity which is likely to further impact on delivery of priorities and leadership capacity to manage change. The majority of factors influencing this risk are outside of C&M ICB's controls (including HR team capacity to deliver change programme, uncertainty of national timelines and of funding for voluntary redundancy schemes).

Key Controls

1. Management of Organisational Change Policy; Grievance & Disputes Policy; Pay Protection Policy
2. People's Operation Group (staff engagement forum); staff engagement forums at 'Place' level
3. Health & Wellbeing support available to all staff
4. System Workforce Dashboard
5. Series of workshops arranged for staff to increase resilience and support wellbeing (mindfulness, self care, CV writing and reflective practice)
6. All staff briefings (We Are One) conducted on fortnightly basis or where key updates require communication.
7. Equality Impact Assessments form integral part of ICB's decision-making processes.
8. Redirection of staff capacity/resources to priority recovery areas

Gaps in Control or Assurance

1. Plan setting out operational arrangements for ICB to manage transitional period (summer to autumn 2026)
2. Mobilisation and engagement plan
3. Board approved Organisational Development (OD) Plan
4. Destination for a series of specific services (including AACC, Meds Management, Spec Comm etc.) still unresolved.

Action

No	Action Required	Due Date	Update On Actions	Progress
1.	Continued, proactive engagement with staff groups to resolve current and emerging workforce concerns	Ongoing	Phase 3 & 8b / below consultation commenced on 25th June 26.	On track
2.	Development of a Transition Plan for the organisation to manage changes planned between summer - autumn 2026.	Oct 26	Transition Plan is currently under development.	On track
3.	Develop Mobilisation and Engagement plan	Sept 26	Management of Change Phase 3 involving wider senior leadership	On track
4.	Organisational development plan/process (to include skills audit)	Apr 27	Draft OD Plan completed end of June 2026. Initial focus on stabilisation & foundational aspects	On track
5.	Work continuing at regional level to develop an 'at scale' solution	Ongoing	NW Change and Transition Coordination Group meeting weekly to resolve	On Track

Date of update: Jul 2026

Date next update due: Sept 2026

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

Billinge Medical Practice

Agenda Item No: ICB/07/30/25/12

Responsible Director: Clare Watson, Executive Director of Health and Integrated Care Commissioning

1. Purpose of the Report

The purpose of the report is to: provide an update on progress regarding the Estates issue relating to the building of Billinge Medical Practice, Recreation Drive, Billinge, WN5 7LY'

2. Executive Summary

Billinge Medical Practice's current premises is owned by former GP partners, the current GP Partnership occupy under 'assumed' lease/occupation terms (no valid lease); the current partnership joined the practice in November 2023 and inherited a failing practice which was put into Special Measures by the Care Quality Commission.

Following an inspection in September/October 2024, the CQC found the practice had made significant improvements under the new provider and its overall rating, as well as the areas of safe, responsive, and well-led, and improved the rating from Inadequate to Good.

The Practice is located close to the border of Great Manchester (Wigan), historically the GP Practice also had a branch surgery in Orrell (owned by the same former partners) who served notice in 2024 and sold the premises.

The Practice sits in St Helens North Primary Care Network (PCN) and is one of 6 PCN Practices, Billinge Medical Practice is the largest practice. Garswood Medical Centre is the closest practice to Billinge Medical Practice and Business Continuity agreements are in place between the two practices.

The landlords of Billinge Medical practice issued a six-month eviction notice on 4 March 2026, following protracted and unsuccessful lease negotiations.

Process

NHS Cheshire and Merseyside has since worked closely with the practice and wider partners to complete an options appraisal to identify a preferred premises solution.

Options considered included:

- Purchase of the existing premises.
- Occupation of space at Billinge Clinic.
- Occupation of space at Edge Hall Road Community Stadium.
- Occupation of space at Birchley Hall.
- Split site options (Billinge Clinic and Edge Hall / Billinge Clinic and Garswood, Billinge Clinic / John Eddleston Community Centre).
- New build facility.

Key assessment criteria included:

- Patient access and continuity.
- Deliverability within the timeframe.
- Clinical safety and quality.
- Workforce sustainability.
- Capital and revenue affordability.
- Patient experience and travel impact.

Decision

Following consideration of a full business case, a recommendation to relocate Billinge Medical Practice to the first floor of Garswood Health Centre was approved by the ICB Executive Committee on 2 July 2026.

Billinge Medical Practice has worked with the ICB throughout this process and is fully supportive of the decision.

Whilst acknowledging the challenges associated with any service relocation, the move to Garswood Heath Centre represents the safest, most deliverable and most sustainable option available to ensure continuity of primary medical services for patients within the required timeframe.

Garswood Health Centre is a high-standard, purpose-built facility, providing stability for Billinge Medical practice and its patients.

A robust mobilisation plan is being developed to support the relocation with a project group to oversee in collaboration with the practice. The ICB is committed to continue working closely with Billinge Medical practice to support the relocation.

The ICB will continue to engage and listen to the views of patients with the practice and ensure that people are supported in relation to the move. The ICB recognises the strength of feeling locally regarding the future provision of services for the Billinge and Orrell communities. The decision to relocate Billinge Medical Practice services to First Floor, Garswood Health Centre is long-term, and it is not planned that practice services will return to the current site at Recreation Drive. However, we recognise the strength of feeling regarding the future provision of services in Billinge and will commit to ongoing assessment and evaluation of this relocation to ensure patient and practice needs are met. Any future potential site options in Billinge would have to be considered as part of our wider primary care and neighbourhood health priorities across Cheshire and

Merseyside. It should be noted any such allocation and planning process takes an extended period of time.

The priority is to maintain accessible, safe and sustainable primary care services – in facilities that are fit for purpose - and preserve continuity of care for patients. We must also ensure affordability and value for money. The ICB will undertake ongoing assessment and evaluation of the relocation to ensure patient and practice needs are being met.

Benefits of relocation to First Floor, Garswood Health Centre

- Stability for the practice – providing more space than the practice currently has.
- Purpose built premises of good standing.
- Retains the practice team on one site.
- Ability to co-locate with another GP practice and community-based services.
- Pharmacy next door.
- Ability to utilise space at Billinge Clinic for PCN outreach services, freeing up space at Garswood Health Centre.
- Distance from current site is approximately 1.8 miles. Short drive (5 minutes) – 20/30 minute walk.
- Situated on Billinge Road, which directly connects the two areas.
- Good car parking.

Key patient information

All current registered patients will remain patients of Billinge Medical Practice, and do not need to take any action. Where medically required, home visits will continue to be available.

All services currently provided from the Recreation Drive site will continue as normal prior to the relocation.

Following the relocation, patients will be able to access the same services with the same level of care. This means:

- Patients will be able to see the same doctors and nurses.
- Opening times will remain the same.
- All clinics and support services will remain the same.

FAQs have been published on the Billinge Medical Practice website and will be regularly updated.

3. Next Steps

Cheshire and Merseyside ICB will continue to work closely with the practice to ensure that patients are engaged and supported in relation to this relocation and are committed to ongoing assessment and evaluation of the move - to ensure patient and practice needs are met.

A robust mobilisation plan is being developed to support the relocation and overseen by an established project group. The ICB is committed to continue working closely with Billinge Medical practice to support the relocation.

4 Ask of the Board and Recommendations

The Board is asked to; Note the contents of this paper

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

- Tackling Health Inequalities in outcomes, experience and access (all 8 Marmot Principles)
- Improve population health and healthcare.

6 Link to meeting CQC ICS Themes and Quality Statements

- Supporting to People to live healthier lives
- Safe and effective staffing
- Equity in access
- Equity in experience and outcomes
- Care provision, integration and continuity
- How staff, teams and services work together.

7 Risks

Risks to delivery will continue to be assessed and mitigated via the project group and escalated as appropriate.

8 Finance

No finance decisions are required for this paper.

9 Communication and Engagement

Public engagement has formed an important part of the options appraisal and review process throughout this period of uncertainty for Billinge Medical Practice.

The Practice has maintained ongoing dialogue with its Patient Participation Group (PPG), recognising the strength of feeling locally regarding the future provision of services for the Billinge and Orrell communities. This engagement has included patient meetings, discussions regarding potential future options, and the collection of patient views, concerns and suggestions regarding accessibility, continuity of care, travel, community impact and future service delivery.

The PPG has actively supported the Practice in gathering feedback and reflecting patient perspectives during the options appraisal process. A range of suggestions and proposals put forward by patients and stakeholders were reviewed and considered as part of the wider assessment process alongside operational, estates, financial, workforce, contractual and clinical factors.

The engagement process has highlighted the importance patients place on maintaining accessible, safe and sustainable primary care services and preserving continuity of care during a period of significant uncertainty.

The Practice and system partners remain committed to continued engagement with patients, staff, local stakeholders, councillors and MPs throughout the mobilisation and implementation phase.

10 Equality, Diversity and Inclusion

The ICB must consider how the move could affect people with protected characteristics and people who may already face barriers to healthcare.

The options appraisal and decision was, therefore, informed by robust equality and quality impact assessments considering factors such as;

- patient geography
- vehicle access
- travel times
- public transport
- walking and car travel distances
- deprivation
- disability
- dispensing pharmacy patterns.

Equality analysis has considered the impact on the following groups;

- Older patients, including people with frailty, sensory impairment or mobility difficulties.
- Disabled patients, including people with physical disabilities, learning disabilities, neurodiversity, dementia, mental ill health or sensory impairment.

- Patients who are pregnant, new parents, carers or dependent on others for transport.
- People who do not have access to a car or who may find public transport difficult, including some patients living in Orrell.
- People on lower incomes, digitally excluded patients, people with low literacy, and people who need information in an accessible format or another language.
- Patients who are housebound, socially isolated or have complex needs that make changes to routine more difficult.

The practice will support patients who think the move may make it harder to attend appointments – whether that's because of age, mobility/disability, caring responsibilities, pregnancy, transport or communication needs - so that they can put in place reasonable adjustments and support as appropriate.

11 Officer contact details for more information

Clare Watson, Executive Director of Health and Integrated Care Commissioning
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Meeting of the Board of NHS Cheshire and Merseyside

30 July 2026

Report of the Chief Executive

Agenda Item No: ICB/07/30/26/13

REPORT SUMMARY SNAPSHOT

Required Information	Details			
Responsible Executive Director	Liz Bishop			
Report approval	**By**	Liz Bishop		
	Date	30 July 2026		
Presented by	Liz Bishop			
Ask of the Board	**Approval**		**Decision**	
	Endorsement		**Ratification**	
	Receive assurance	✓	**Note**	✓
Route to Board – where has this report been discussed	n/a			
ICB Strategic Objective(s) the report relates to	**Tackling Health Inequalities in access, outcomes and experience**	✓	**Improving Population Health and Healthcare**	✓
	Enhancing Productivity and Value for Money	✓	**Helping to support broader social and economic development**	✓
Board Assurance Framework Risk(s) the report relates to*	P12 – Failure to reduce health inequalities and improve population health P14 – Failure to recover access and performance standards			
Financial Implications*	**Yes**		**No**	✓
	If Yes:			
	Have the financial implications been reviewed by the Director of Finance			n/a
	Has a budget been identified			n/a
Legal Implications*	n/a			
Conflicts of Interest associated with this report	n/a			
Impact assessments undertaken*	**Equality**			n/a
	Quality			n/a
	Data			n/a
	Sustainability			n/a
Public or Clinical engagement undertaken	n/a			

Report of the Chief Executive (July 2026)

1. Introduction

1.1 This report covers highlights of the work which takes place by the Integrated Care Board at a senior level and also key developments in health and care for Board information which is not reported elsewhere in detail on this meeting agenda.

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

2. Ask of the Board and Recommendations

2.1 The Board is asked to:

- **consider** the updates to Board and seek any further clarification or details;
- **disseminate** and cascade key messages and information as appropriate.

3. Key Updates

3.1 Launch of Management of Change for bands 8b and below

NHS Cheshire & Merseyside ICB has launched formal collective consultation on the proposed Band 8b and below organisational structure, running from 25 June to midnight 9 August 2026.

The process follows the ICB's Management of Organisational Change Policy, with roles filled through slotting-in, ring-fencing, suitable alternative employment and then recruitment to remaining vacancies.

A further targeted Voluntary Redundancy process is open to eligible colleagues, with applications closing 26 July 2026, settlement agreements issued by 10 August, and planned exits on 30 September 2026.

Staff engagement, wellbeing and transparency are central to the approach. Affected colleagues have received consultation documents, job descriptions, FAQs and support through line managers, HR, trade unions, occupational health, financial/pension advice and career development resources. Feedback will be reviewed before the final structure is approved, with consultation outcomes expected to be issued in w/c 17 August 2026.

3.2 Race Equity Assembly – Annual Report

The NHS North West Race Equity Assembly Annual Report 25.26 has recently been published and highlights that significant racial inequalities continue to affect both NHS staff and patients, including barriers to career progression, experiences of bullying and racism, under-representation in senior leadership and poorer health outcomes for some ethnic minority communities. The report emphasises that anti-racism should be viewed as a core component of organisational effectiveness, patient safety and quality improvement rather than as a stand-alone equality initiative.

The report demonstrates growing adoption of the NHS North West Anti-racist Framework (ARF), with more than 90% of NHS organisations in the region committed to the framework and 48% achieving Bronze recognition. Examples from Integrated Care Boards and provider organisations show that progress is most effective where there is visible board-level leadership, clear accountability arrangements, robust workforce data monitoring and the integration of anti-racist principles into commissioning, workforce planning and service delivery.

The report also identifies several areas requiring further action, including inconsistent leadership accountability, limited confidence in reporting mechanisms and gaps in organisational capability to respond to racism. The ICB should therefore prioritise leadership development, support staff networks, improve ethnicity data quality, strengthen community engagement and co-production, and establish a clear improvement plan aligned to progressing through the Anti-racist Framework. This will help demonstrate measurable progress, improve staff experience and contribute to reducing health inequalities across the population it serves.

3.3 Lord Mann Review

On 4 June 2026 Lord Mann published his review into tackling racism and antisemitism within the NHS - with recommendations to support our shared goal of making our services safe for all patients, communities and colleagues.

Just like wider society, the NHS is not immune to the persistent and systemic challenges of all forms of racism (including antisemitism and Islamophobia), discrimination and inequality, and we all have much more to do.

Lord Mann's review set out a range of recommendations for NHS organisations and leaders. Collectively, these measures aim to:

- strengthen leadership and accountability,
- improve understanding and capability through training and development,
- set clear expectations regarding political identifiers and inclusive practice,

- improve and standardise support and protection for staff who experience racism, improve the consistency, quality and application of data relating to racism

These recommendations will help NHS organisations strengthen the way we drive change and focus on ensuring that Cheshire and Merseyside is a place of compassion, care and unity – not conflict or discrimination. Achieving this requires us all to be honest about the challenges we face and take strong action to address them.

Tackling all forms of racism within the NHS in Cheshire and Merseyside will require a joined-up, concerted effort at every level – and we should all be acutely aware of the racial abuse and harassment our colleagues and patients are subject to.

Antisemitism and all forms of racism have no place in the NHS. Patients should never feel anxious when receiving care and no member of staff should ever feel isolated, intimidated or unwelcome in their workplace.

The Lord Mann review gives us the opportunity to raise our standards and expectations about what we will accept and put our professional values of care, compassion and clinical excellence first.

We will now carefully consider the recommendations of the Lord Mann Review into tackling racism and antisemitism in the NHS.

3.4 National leader's visits Cheshire and Merseyside to explore our approach to neighbourhood health development

NHS England's Primary Care Medical Director, Dr Claire Fuller, visited Cheshire and Merseyside on 22 June to find out more about local neighbourhood health development.

The visit – held at Alder Hey Children's Hospital as part of a round of national visits to health and care systems across the country – provided an opportunity to showcase examples of collaborative work across Cheshire and Merseyside and highlight some of the challenges and areas which require national support.

Representatives of Cheshire and Merseyside's two neighbourhood health 'pioneers' – Sefton and St Helens – presented on local neighbourhood care approaches. In Sefton, aligned to the demographics of the local population, the approach to date has centred around supporting people with frailty, while the St Helens presentation focused on how they are optimising multi-disciplinary teams to provide increasingly proactive, holistic care.

A well-received presentation around population health management – led by Andrea Astbury, Nush Sivananthan and David Hammond – was then followed by presentations about the implementation of multi-disciplinary neighbourhood teams for children and young people and the co-ordination of unscheduled care via a streamlined single point of access.

Executive Director of Health and Integrated Care Commissioning Clare Watson also presented a broad overview of the neighbourhood health approach to date, while a lively question and answer session covered topics including the shape of Cheshire and Merseyside's 58 neighbourhoods, lines of accountability, use of data and approaches to supporting the 1% of people who are most frequent users of reactive NHS services.

Dr Fuller praised the examples presented on the day and the culture of healthy check and challenge among the partners in the room – including NHS Cheshire and Merseyside, Cheshire and Merseyside Provider Collaborative and NHS Trusts, Primary Care and Local Authority and voluntary sector representatives.

She also complimented the local model for neighbourhood health development, the emphasis on children and young people and complex families and noted that Cheshire and Merseyside's approach to digital and data.

3.5 Partners come together to focus on improvements in frailty care across Cheshire and Merseyside

More than 60 colleagues from across the NHS, local authorities and partner organisations recently came together to explore how Cheshire and Merseyside can improve care and support for people living with frailty.

Held at Liverpool's Cunard Building on Friday 5 June, the frailty improvement workshop brought together professionals from across the system to share expertise, discuss common challenges and identify opportunities to work more effectively across multiple organisations.

Supporting people living with frailty is one of the key priorities in NHS Cheshire and Merseyside's Five-Year Commissioning Plan.

Figures show that more than 800,000 people across Cheshire and Merseyside are living with frailty.

In the last 12 months alone, more than 126,000 attended A&E, while there were more than 62,000 emergency admissions involving people living with frailty.

Delegates explored frailty through the lenses of population health, primary care and social care, while colleagues from Greater Manchester, Liverpool City Region, East Cheshire and the Cancer Alliance shared their experiences of improving care and outcomes for people living with frailty.

Participants also heard directly from people with lived experience through a video exploring what living with frailty is like from the perspective of a carer.

A key theme throughout the day was the importance of listening to the voices of patients and carers.

Feedback highlighted the need for care that feels joined up, with better coordination between services so people do not have to repeat their story across different services. Patients and carers had also stressed the importance of clear, accessible communication and greater support to help them navigate a complex health and care system.

Following the workshop, a Cheshire and Merseyside Frailty Collaboration will be developed, building on the strong work already taking place across the system, taking forward new ideas from the workshop, and scaling and spreading best practice across organisations.

Find out more about NHS Cheshire and Merseyside and partners will support people living with frailty in the Five-Year Commissioning Plan.

3.6 OPIC - Office for Pan-ICB Commissioning: National Context and North-West Arrangements

The Office for Pan-ICB Commissioning (OPIC) is a new national model mandated by NHS England (NHSE) and the Department of Health and Social Care (DHSC) to be led by Integrated Care Boards (ICBs) in regions in taking on a wider strategic commissioning role. As confirmed in national guidance and the 2 March 2026 letter (Direct commissioning update), the majority of NHSE's direct commissioning functions—including specialised services, health and justice services, and vaccination and screening—are expected to transfer to ICBs from April 2027, subject to legislation.

To enable this transition to an ICB-led OPIC model while maintaining consistency and expertise, NHSE requires the establishment of seven OPICs, one in each NHS region. OPICs will operate as regional centres of commissioning excellence, enabling collaboration between ICBs to plan and commission services at scale, improve equity and outcomes, and ensure resilience in delivering complex and high-cost services. National requirements specify that each OPIC must be hosted by a single ICB on behalf of all ICBs in the region, operate through formal joint ICB governance arrangements (such as a joint committee), and support both ICB strategic and operational commissioning in a region. While OPICs will facilitate collective decision-making, statutory accountability will remain with individual ICBs.

In the North West, NHS Lancashire and South Cumbria (LSC) ICB has been collectively agreed as the host organisation for OPIC, working in full partnership with NHS Greater Manchester (GM) ICB and NHS Cheshire and Merseyside (CM) ICB, which was formalised in May this year. The three ICBs, supported by the NHSE North West regional team, have established a collaborative programme to design and implement OPIC arrangements. This includes the North West OPIC Programme Development Board, which brings together senior leaders across the partner organisations to oversee delivery, linking with ICB Executive level oversight and governance arrangements. ICB Boards and related Transition Committees have been regularly informed of these developments.

The North West OPIC will initially focus on delivering the nationally mandated "OPIC Core" functions, including specialised commissioning, health and justice services, vaccination and screening, and Child Health Information Services, with the potential to extend to additional "OPIC Plus" services where this adds value in the region. The OPIC ICB partnership aims to strengthen strategic commissioning capability in line with the Model ICB Blueprint of May 2025, improve consistency and equity of services, and maximise the effective use of public resources across the region, aligned to the national NHSE Strategic Commissioning Framework.

Implementation will follow a phased approach. A "shadow" OPIC is planned to be in place by autumn 2026 to test governance, operating models and ways of working, ahead of the formal transfer of functions and staff from NHSE North West Specialised Commissioning to LSC as host ICB in April 2027 in partnership with CM ICB and GM ICB. New joint governance arrangements will also be established to reflect the expanded scope of commissioning responsibilities with consideration of revised arrangements through the current North West Specialised Commissioning Joint Committee.

Overall, the establishment of OPIC represents a significant step in enabling ICBs to act as strategic commissioners for their local populations, supported by strong regional collaboration and national standards, with the North West partnership working collectively to deliver these ambitions.

3.7 Intensive and Assertive Outreach (IAO) – Community Mental Health Update

This update responds to NHS England's requirement for ICB Boards to receive regular assurance on the system's ability to identify, engage and support people requiring intensive and assertive community mental health care, particularly following the Nottingham homicides in June 2023.

The Board can be assured that both Cheshire and Wirral Partnership Foundation Trust and Mersey Care Foundation Trust have made good progress since the last update, provided in March 2026. Significant developments include implementation of the regional IAOT framework, strengthened governance oversight, improvements to non-engagement processes and progress in identifying people requiring intensive and assertive support. Cheshire and Wirral Partnership has now implemented a digital patient identification flag within its electronic patient record (EPR), while Mersey Care has established strengthened implementation oversight through weekly executive review.

However, both organisations acknowledge that implementation is not yet fully complete. Continued focus will be required during the remainder of 2026 to embed practice consistently, improve audit and assurance arrangements, complete EPR developments, and strengthen system-wide partnership working so that people with severe mental illness who are at risk of disengagement

receive timely, safe and responsive care.

To address ongoing challenges in information sharing and early identification of relapse, NHS England has approved capital funding to support development of digital interoperability and alerting systems. A workshop is being co-facilitated by the Cheshire and Merseyside Mental Health and Digital Programmes on 16th July 2026 to collaboratively define digital system requirements.

Overall delivery remains on track, with key governance and infrastructure elements now in place. A further detailed progress report, including provider assurance, will be presented to Board in October 2026.

3.8 CMPC supports the shift from acute to community-based outpatient care

CMPC is leading on a 3-year system-wide programme to implement an Integrated Referral Model for elective care across Cheshire and Merseyside.

The programme aims to safely reduce demand on acute-based services by providing clinical triage and outpatient services as part of a new neighbourhood model of care. This will help cut waiting times, improving patient access and health equity through more care being given closer to home. In turn, it will support delivery of national planning requirements to decrease waiting lists and improve Referral to Treatment 18-week performance targets.

Plans include the implementation of at scale Single Points of Access (SPOAs), community-based Tier 2 services and straight to test pathways for a range of high-volume specialties and symptom-based pathways. The SPOA services within the community will act as an interface between primary and secondary care. Consultants will be available, when necessary, as part of a Multidisciplinary Team-based approach.

3.9 Trusts collaboration rules out skin cancer faster for thousands of Cheshire and Merseyside patients

As part of CMPC, six NHS trusts are using the latest artificial intelligence (AI) technology to provide patients with a swifter diagnosis of skin cancer.

The number of new melanoma skin cancer cases diagnosed per year has risen above 20,000 for the first time in the UK, according to Cancer Research UK. And, with skin cancer now accounting for approximately half of all cancers in England and Wales, there is a high demand for dermatology services.

In Cheshire and Merseyside, the two-week wait cancer pathway alone accounts for over 45,000 referrals each year. CMPC secured £1 million national pilot funding to address this, enabling the introduction of Skin Analytics' NICE-recommended AI technology, DERM, reducing waiting times and freeing up NHS resource.

DERM recognises cancerous, pre-cancerous and common harmless skin conditions through photographic images taken of a patient's mole or skin lesion. AI assessment of these results in a faster diagnosis. Patients with common harmless skin conditions can be quickly discharged, with consultants' time freed up for those most in need. If any skin lesions are flagged as potentially pre-malignant or malignant, they receive faster access to care.

In Cheshire and Merseyside, in 2025-26, 4,640 unnecessary face-to-face appointments were avoided in this way, with significant time and money saved as a result of reduced outpatient appointments and biopsies.

3.10 Oral Nutritional Supplements project to improve quality of patient care and deliver an estimated £6 million cost savings

Oral nutritional supplements (ONS) are used to support a patient's nutritional Intake when normal food isn't enough, helping manage or prevent malnutrition. In NHS Cheshire and Merseyside, ONS prescribing remains high, with the second highest number of items prescribed per 1,000 population in England and the fifth highest spend.

This has continued to rise, from £13 million in 2021/22 to £19 million in 2025/26. A new project is addressing this situation, which is unsustainable in terms of cost, workforce capacity, patient experience and environmental impact. This has been co-ordinated by CMPC in collaboration with the ICB Chief Pharmacist and registered dieticians across Cheshire and Merseyside.

Through it, a number of issues have been identified, including inconsistent prescribing practices, workforce and system pressures, inefficiencies and sustainability.

In response, the programme is supporting a more consistent, clinically led approach to nutritional care, including the development of a system-wide policy and ONS formulary.

This will standardise prescribing, support clinicians and ensure equitable patient access. The new Nutrition Review and Support Service, commissioned by Cheshire and Merseyside ICB and hosted by Mersey Care NHS Foundation Trust, underpins this work, through implementing a dietitian-led model.

As well as improving quality of care and patient outcomes, the project will reduce the primary care workload and deliver an estimated cost saving of £6 million by year end. Pilot projects in South Sefton and Liverpool have shown that around 60% of patients could have ONS discontinued, with a further 20% switched to more cost-effective alternatives, giving scope for ongoing savings.

3.11 CMPC joins with region to deliver shortest diagnostic waiting times in England

CMPC Diagnostics Programme Director Tracey Cole-Wetherill spoke at the NHS Confed Expo 2026 conference on Thursday 11 June.

Presenting on behalf of CMPC it was explained how in August 2024, the Northwest became the top region (out of 7 in England) for diagnostics performance, with 80% of patients being seen within 6 weeks. This top position has been maintained for over 18 months, despite increasing waiting lists. In April 2026, 84% of patients received their test within 6 weeks. With 95% of patient pathways requiring a diagnostic test, this has a significant impact on all healthcare.

To achieve this, NHSE's North West regional team, Cheshire and Merseyside, Greater Manchester, and Lancashire and South Cumbria Diagnostic Programmes have worked with providers to maximise productively, reduce inappropriate referrals and increase access to tests with newly opened Community Diagnostic Centres.

A collaborative, system first approach has proved critical, alongside a commitment to reduce health inequalities. Focus on timely, accurate data has meant that planning submissions and live data can now track progress, with regular monitoring supporting earlier intervention.

3.12 New community digital wound care service to improve patient recovery time, release community nursing hours and reduce cost of care across Cheshire and Merseyside

A key aspect of CMPC's role is to identify, share and enable best practice at scale, for the benefit of our patients and trusts across Cheshire and Merseyside.

Wound care accounts for half of all community nursing visits, with more than 200,000 patients across Cheshire and Merseyside living with chronic wounds each year. The average cost to the NHS of a non-healing wound is nearly £4,000.

West Cheshire Health Collaborative's new digital wound care service is designed to address this.

Using innovative technology, the service enables virtual monitoring, digital assessment of wound area and tissue distribution at first assessment, and ongoing tracking of treatment effectiveness. A secure portal also gives community nursing teams access to remote expert advice and support.

Launched in July 2025, the service has already cut the average wound healing time from 46 days to 32.5, with nursing visits significantly reduced, up to 40% in specific

cases. As care shifts from analogue to digital and from hospital to community, alongside an anticipated 3% annual rise in community care, this is a timely alternative to more traditional models of care.

3.13 Beyond Programme Delivered Health, Exercise and Nutrition for the Really Young (HENRY)

Beyond has delivered the Health, Exercise and Nutrition for the Really Young (HENRY) evidence--based family lifestyle programme as a core part of its Healthy Weight workstream since 2023. Partnering with all nine Cheshire and Merseyside Local Authorities in phase 1 and eight in phase 2, trained practitioners have delivered 42 eight--week programmes and 257 standalone workshops, supporting 1,445 families to build healthier, happier routines. Family feedback shows a positive impact with 94% reporting leading a healthier lifestyle after completing a programme, and 88% feeling more confident addressing the topics explored in their workshop. Six Place areas have committed to sustaining HENRY delivery into 2026/27 through local funding, demonstrating strong confidence in its impact.

3.14 Innovative Stroke Rehabilitation programme wins national award

A pioneering online rehabilitation service supporting stroke patients across Cheshire and Merseyside has received national recognition after winning a top award at the Advancing Healthcare Awards 2026 in London.

The NeuroRehabilitation OnLine (NROL) service received the award for Best Collaboration Across Clinical, Academia and Industry, recognising the strong partnership between clinicians, researchers, NHS organisations, patients and carers.

The accolade reflects the collective effort to redesign rehabilitation services to make them more accessible, effective and patient-centred.

In a highly competitive category, judges praised the collaborative approach that underpins NROL and its impact on improving patient care.

The Cheshire and Mersey NROL service, which launched in 2024 and is hosted by the Countess of Chester Hospital NHS Foundation Trust, delivers rehabilitation to stroke patients through real-time, therapist-led group sessions.

Delivered virtually via Microsoft Teams, the programme brings together NHS therapists from hospital trusts across Cheshire and Merseyside to provide a range of support including physical rehabilitation, cognitive therapy, talking therapies and community-based sessions.

By enabling patients to access therapy from their own homes, NROL helps to increase both the frequency and intensity of rehabilitation, whilst also building

confidence, promoting self-management and reducing isolation through group-based support.

The initiative has been supported by the Stroke Quality Improvement for Rehabilitation (SQuIRe) programme and is available to patients receiving care through a range of NHS trusts across the region, including the Countess of Chester Hospital NHS Foundation Trust and Cheshire and Wirral Partnership NHS Foundation Trust.

This latest accolade recognises the hard work and dedication of the Cheshire and Mersey Stroke Network, clinicians and the NROL team, as well as the vital contribution of patients and partners who have helped shape and develop the service.

Executive Committee Activity – Covering meetings: 21 May, 4 June, 18 June and 2 July 2026

3.15 Purpose

To provide the Board with assurance on delivery, governance, finance, quality and system risk based on discussions and decisions taken by the Executive Committee, and to highlight matters requiring Board awareness or oversight

3.16 Organisational Transition and Governance

The Committee maintained oversight of organisational transition, workforce changes and implementation of the revised operating model. Work included staff engagement, recruitment progress, leadership arrangements, matrix working, governance development and improved assurance structures.

The Committee also considered the establishment of a new Operational Assurance Group to strengthen organisational oversight of compliance, risk and operational assurance matters.

The Committee continued to monitor risks associated with OPIC and the transfer of NHS England functions, including risks related to potentially unfunded or expanded responsibilities, workforce implications and governance arrangements.

3.17 Financial Recovery and Performance

The Committee received regular updates on:

- System financial performance and delivery of the CIP/CRES programme
- Oversight of NHS provider financial positions
- Provider contract sign-off and performance management
- Financial risks associated with continuing care, provider recovery and activity management

- Potential support arrangements and wider provider sustainability

3.18 Left Shift and Strategic Commissioning

The Committee's work continued to emphasise that transformation funding should support sustainable service redesign and patient benefits.

A number of discussions took place regarding the three-year Left Shift programme. Following assessment of over 60 proposals, the Committee reviewed prioritised work programmes and agreed a focus on alignment and working up opportunities on schemes capable of delivering tangible system benefits, particularly ahead of winter. Priority areas included:

- Integrated urgent care and single front door models
- Planned care referral management
- Community-based alternatives to hospital activity
- Frailty and intermediate care schemes
- Mental health services
- Children and young people's neurodiversity pathways
- Use of elastomeric devices to support home IV antibiotic treatment

3.19 Quality, Safety and Clinical Assurance

The Committee continued oversight of:

- SEND reform and local area improvement plans
- Southport Inquiry actions
- East Cheshire mortality
- Safeguarding and patient safety programmes.
- Corridor care reviews
- Operation Decker
- Continuing Care governance and oversight arrangements

3.20 Estates, Primary Care and Neighbourhood Health

The Committee continued to oversee:

- GP New Build Assessment Framework development
- Neighbourhood Health Centre planning submissions
- Capital planning and neighbourhood estate development
- Primary care estate proposals

Detailed consideration was given to the future of Billinge Medical Centre and wider primary care estate schemes, ensuring patient safety, sustainability and value for money remained central to decision making.

3.21 Better Care Fund and Integrated Care

The Committee reviewed Better Care Fund arrangements and approved a Technology Enabled Care investment in Liverpool. Discussion identified the

need for stronger outcomes measurement, governance and alignment with neighbourhood health and prevention priorities.

3.22 Clinical Policy, Prescribing and Service Change

The Committee considered:

- Harmonised clinical commissioning policies
- NICE technology appraisal implementation
- Wheelchair service changes
- Autism pathway planning
- Continuing Care authorisation processes
- School-based eye care services
- COPD biologic therapy implementation
- Appropriate Places of Care arrangements for children and young people

3.23 Key Decisions and Approvals

21 May 2026 The Committee:

- Approved progression of four revised breast clinical policies to public engagement
- Approved implementation of NICE TA1128 (Budesonide for IgA nephropathy)
- Approved implementation of NICE TA1140 (Ruxolitinib cream for vitiligo)
- Endorsed adult autism service activity plans

4 June 2026 The Committee:

- Approved the Coding Assurance Business Case
- Approved revised Executive Committee Terms of Reference
- Approved Sprint funding allocations and a £50k elective care management investment
- Approved Longview and Bridgewater contract variations
- Retrospectively approved the Neighbourhood Health Centre submission (due to NHSE deadline submission requirements)

18 June 2026 The Committee:

- Ratified termination of the C2Ai contract
- Approved revised Continuing Care package authorisation arrangements
- Approved award of the Special Education Settings Eye Care Service contract
- Approved Liverpool's five-year Technology Enabled Care programme (£15m)

2 July 2026 The Committee:

- Ratified the Service Change Panel recommendation regarding wheelchair service relocation arrangements
- Approved commencement of a system-wide maternity and neonatal services review
- Endorsed establishment of the Operational Assurance Group and draft governance arrangements

- Approved relocation of Billinge Medical Centre to the Garswood facility .
- Approved progression of CSU Digital Services transition into Informatics Merseyside
- Supported implementation of NICE-approved COPD biologic therapies
- Agreed publication of updated clinical policies, including grommet and split ear lobe policies, subject to appropriate governance oversight
- Agreed the ICB position on Appropriate Places of Care funding arrangements for children and young people

3.34 Overall Assurance

The Executive Committee remains focused on delivering organisational recovery and transformation through strengthened governance, financial discipline, strategic commissioning, quality improvement and neighbourhood-based care. During this period the Committee approved several significant commissioning, digital, estates and service transformation decisions while maintaining oversight of major organisational risks and national policy changes

4. APPENDICES

N/A

5. Officer contact details for more information

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NHS
Cheshire and Merseyside

Meeting of the Board (Public) of NHS Cheshire and Merseyside

30th July 2026

ICB Financial Position – Month 3

Agenda Item No: ICB/07/30/26/14

Responsible Director: Andrea McGee, Executive Director of Finance

ICB Financial Position – Month 3

1. Purpose of the Report

1.1 This report provides an update to the Board on the financial performance of Cheshire and Merseyside ICB at Month 3 2026/27.

2. Executive Summary

2.1 The year-to-date financial position is in line with plan, the ICB is reporting a breakeven position at Month 3.

2.2 The ICB Cost Reduction and Efficiency Schemes (CRES) programme is reporting a £0.6m adverse variance year-to-date. However, the full £144m CRES target has now been identified, with schemes totaling £154m. Delivery is expected throughout the remainder of the financial year.

3. Financial Position as at Month 3

3.1 As per the summary table below, the ICB is reporting a breakeven position at Month 3. A brief commentary on the key lines of expenditure is provided below:

ICB Total	C&M ICB TOTAL - Month 3		
	Budget £'m	Actual £'m	Variance £'m
Acute	946	943	3
Community	188	189	(1)
Mental Health - Contracts	152	153	(1)
Mental Health - Packages of Care	57	60	(3)
CHC	115	112	3
Delegated GP	158	157	2
Delegated Other - DOP	86	71	14
Prescribing	139	140	(1)
Primary Care Other	32	33	(1)
Other Commissioned Services	5	5	0
Other Programmes	9	12	(3)
Reserves	(13)	0	(13)
Specialised Commissioning	216	216	0
Sub Total - Programme Expenditure	**2,090**	**2,090**	**0**
Running Costs	11	11	0
TOTAL EXPENDITURE	**2,101**	**2,101**	**0**
Surplus / (Deficit) Plan	*0*	*0*	*0*
Sub Total - Net Surplus / (Deficit) Reported	***2,101***	***2,101***	***0***

Key areas to highlight are set out below:

- **Acute Services £3m favourable:**
  Elective and Diagnostic activity is below plan, primarily due to the impact of industrial action. Independent Sector providers are delivering activity in-line with ICB agreed plans. Liverpool University Hospitals NHS Foundation Trust (LUHFT) has reported non-elective overperformance, which is currently under review.

- **Community Services (£1m) adverse:**
  Re-ablement budgets are overspent year-to-date due to increased spending on P3 beds in Cheshire and an overspend on the Knowsley pooled budget.

- **Mental Health Contracts (£1m) adverse:**
  Overspend YTD due to new market entrants. Indicative Activity Plans (IAPs) have been issued to these providers to manage activity levels for the remainder of 2026/27.

- **Mental Health Packages of Care (PoC) (£3m) adverse:**
  The overspend is driven by an increase in patient numbers and higher expenditure on Mental Health inpatient care and Mental Health Act related (s117, MH & LD) placements.

- **Adult Continuing Care (AACC) £3m favourable:**
  Lower than budgeted patient numbers and underspends against Personal Health Budgets, Fast Track PoC, and Funded Nursing care are driving a favourable variance year-to-date. This currently offsets the increase in Mental Health.

- **Delegated Primary Medical Services £2m favourable:**
  There is a one-off benefit brought forward from 25/26 of c£2m relating to activity related payments e.g. Quality Outcomes Framework (QoF) and Minor Surgery.

- **Pharmacy, Optometry and Dental (POD) £14m favourable:**
  Of the £14m month 3 reported underspend, £4m relates to 2026/27 activities where there are currently no confirmed commitments. This is being monitored closely, recognising that it is still early in the financial year and that there remains a possibility that some of these funds may be required as plans and contractual commitments develop. A further £10m relates to prior year, where actual activity levels were significantly lower than originally anticipated.

- **Prescribing £1m adverse:**
  The Prescribing budget is reporting a c£1m overspend. Items and costs per dispensing day both increased by 3% compared with the same period last year.

- **Reserves (£13m) adverse:**
  The adverse variance on reserves is driven by a combination of unidentified CRES at the planning stage (£29m) and expected savings from a balance sheet review (£4m).

3.2 Year-end forecasts will form part of the formal reporting to the Finance, Investment, and Contracting Committee and ICB Board with effect from month 4. This is earlier that would typically be the case but will demonstrate a level of grip and control and give a greater level of confidence in financial reporting.

4. CRES Delivery

4.1 The CRES reported as of 30th June 2026 is £0.6m adverse (see **Table 1**). This is due to the profile of unidentified savings submitted within the ICB's initial financial plan. All savings are now identified. The ICB has set an ambition to achieve £154m and exceed the plan by £10m, which supports de-risking the plan and provides potential opportunity for reinvestment.

Table 1: CRES month 3

Programme / Workstream	CRES Target (Plan) (£000's)	Additional CRES Target (£000's)	Total CRES Target (£000's)	YTD Plan M3	YTD Actual M3	YTD Variance M3
ADHD	4,216	1,000	5,216	0	0	0
Contract and Investment Review	10,953		10,953	231	224	-8
Digital	1,000		1,000	5	182	177
Estates	2,246		2,246	217	18	-199
Grip & Control	12,500	5,873	18,373	2,784	5,792	3,008
Independent Sector Contract Management	5,000	4,000	9,000	0	1,786	1,786
Individual Patient Commissioning	23,794		23,794	2,673	2,416	-257
Management Cost Reductions	21,897		21,897	3,872	4,210	338
Mental Health Redesign	3,611		3,611	524	102	-422
Planned Care	2,000	3,000	5,000	0	1,516	1,516
Prescribing	25,512	22,354	47,866	8,713	9,283	570
Urgent & Emergency Care	3,000	2,000	5,000	0	0	0
Unidentified	28,302	-28,302	0	7,076	0	-7,076
Grand Total	**144,030**	**9,925**	**153,955**	**26,094**	**25,529**	**-565**

4.2 The forecast is currently £11.4 above the plan, however when the forecast is risk adjusted to reflect the current delivery status, this reduces the forecast to £12m below plan.

4.3 Work is on-going to continue to move schemes through the pipeline into fully implemented to ensure the plan is delivered and in the best case, exceeded.

5. 26/27 Contract Status

5.1 The main contracts being negotiated include the following:

- 15 - Local Acute, Community and Mental Health Providers
- 24 - Local Independent Sector (IS) Providers
- 16 - Out of Area Providers where the ICB is a 'co-commissioner'

5.2 All local contracts for Cheshire and Merseyside NHS providers are now agreed with one to be signed (at the time of writing).

5.3 All 24 IS provider Indicative Activity Plans have now been agreed, or 'set' and no provider has escalated the ICB into dispute giving the ICB firm plans to monitor against. Setting the IAPs for all IS providers and undertaking a broader coding audit should deliver the £9m additional savings required this financial year. Early indications are that this is already starting to be achieved.

5.4 Regarding the out of area NHS Trust contracts, all contracts are now agreed at an overall financial level although the split between the fixed and variable payments are yet to be finalised for a small number of Trusts, however this is not material.

5.5 Work is also progressing on negotiating all other contracts and is being

prioritised based on contract size and risk, however due to the sheer volume involved, some contracts may continue implied terms for a period. To give an indication of the volumes involved, more than 800 contracts for All Age Continuing Care have been issued and circa 20 have been returned as signed.

6. Cheshire & Merseyside ICS Position

6.1 From 2026/27, NHS trusts and ICBs are expected to deliver breakeven positions as individual organisations, replacing the previous emphasis on system-wide control totals. However, the financial position across the Cheshire and Merseyside system is still critical to ICB success and overall sustainability.

6.2 At month 3 there is a £7m adverse variance to plan (see **Table 2**). Three providers are reporting adverse variances, largely driven by the impact of Industrial Action and non-delivery of Cost Improvement Plans (CIP).

Table 2: ICS position month 3

		M3 YTD excl DSF Sheet 99, sub code KEY0122			
		YTD plan £000	YTD actual £000	YTD Var £000	YTD Var % of YTD Plan turnover %
RBL	Wirral Teaching	(8,488)	(8,463)	25	0.0%
RBN	Mersey & W Lancs	(11,015)	(10,986)	29	0.0%
RBQ	Liverpool Heart & Chest	1,505	1,516	11	0.0%
RBS	Alder Hey	(2,785)	(2,784)	1	0.0%
RBT	Mid Cheshire	(9,289)	(9,308)	(19)	0.0%
REM	LUHFT	(11,328)	(17,444)	(6,115)	-1.8%
REN	Clatterbridge	250	254	4	0.0%
REP	Liverpool Women's	(6,293)	(6,290)	3	0.0%
RET	Walton Centre	(306)	(290)	16	0.0%
RJN	East Cheshire	(4,857)	(4,848)	9	0.0%
RJR	Countess of Chester	(11,100)	(11,099)	1	0.0%
RW4	Mersey Care	(1,152)	(1,052)	100	0.1%
RWW	North Cheshire and Mersey	(13,368)	(14,292)	(924)	-0.9%
RXA	CWP	5	22	17	0.0%
RY7	Wirral Community	474	746	272	1.0%
	Total C&M Providers	**(77,748)**	**(84,318)**	**(6,570)**	
QYG	Cheshire & Mersey ICB	0	0	0	0.0%
	Total C&M	**(77,748)**	**(84,318)**	**(6,570)**	

7. Risks and Mitigations

7.1 The key financial risks at Month 3 are as follows:

- Provider activity plans including Independent Sector do not deliver required RTT improvements which results in further funding required to deliver additional activity.
- Non-Elective over-performance is above planned contingency.
- Prescribing/High-Cost Drugs expenditure is above local horizon scanning e.g. in year price changes/Tirzeptide increases.
- AACC/MH & Complex Packages of Care cost increase above local planning assumptions (complexity and price inflation).
- ADHD continues to grow due to increase in demand including expansion of IS providers in the market under Right to Choose.
- CRES schemes do not deliver efficiencies required in year.

7.2 Mitigating actions are in place. These include strengthened grip, control and oversight of the CRES programme, together with a revised approach to contract management and performance oversight. The ICB continues to be scrutinised through Financial Performance Review Meetings (FPRM's) with PWC and NHSE. The Finance Committee is undertaking detailed reviews of key areas of financial risk. Risk and mitigations will continue to be actively monitored and reported through the Executive Committee, Finance Committee and FPRM process.

8. Recommendations

8.1 The board is asked to:

- Note the ICB and ICS financial position at month 3 (June 2026); and
- Acknowledge the financial risks highlighted within this report.

Andrea McGee
Executive Director of Finance, Cheshire and Merseyside ICB
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Meeting of the Board of NHS Cheshire and Merseyside

30 July 2026

Highlight report of the Chair of the Finance, Investment, and Contracting Committee (FICC)

Agenda Item No: **ICB/07/30/26/15**

Committee Chair & Deputy: **Sue Lorimer and Mike Burrows**

Highlight report of the Chair of the Finance, Investment, and Contracting (FICC) Committee

Committee Chair	Sue Lorimer
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	21st May and 17th June 2026

Key escalation and discussion points from the Committee meeting

Alert

Finance, Investment and Contracting Committee (FICC), 21st May 2026

26/27 CRES Delivery

- The Committee considered the current position on 26/27 CRES development and associated financial risk, noting:
    - Although >100% of savings have been identified (£154m against a target of £144m), delivery confidence reduces the forecast delivery to c.£120m when risk-adjusted, indicating a potential delivery gap of £24m.

Demand led Cost Pressures

- The Committee discussed demand led cost pressures within Continuing Healthcare, Prescribing and ADHD pathways, that will need careful monitoring throughout the financial year. However, the organisation is in a stronger position than in previous years, with improved governance, earlier identification of savings, and more mature programme management arrangements in place.

System Financial Risk

- A System-wide financial deficit of c£7.8m is reported at Month 1, driven largely by industrial action cost and impact on activity income, and CIP under-delivery. The Committee noted that financial risks in the wider system will continue to impact on ICB performance.

Contracting and Procurement

- Ongoing dispute with Mersey and West Lancashire NHS FT relating to complex historic funding arrangements (including PFI and System top-up), with escalation to NHSE region.
- Independent sector providers may escalate Indicative Activity Plans (IAPs) disagreements to NHS England.
- NEPTS procurement required abandonment due to an error in the financial envelope, creating legal challenge risk and requiring full re-procurement.

ICB Management of Change

- The Committee discussed workforce instability and the impact of organisational change and the risk this presents to delivery of financial recovery programmes.

Finance, Investment and Contracting Committee (FICC), 17th June 2026

26/27 CRES Delivery

- The CRES position remains unaltered from the May report, CRES delivery remains backloaded, increasing risk to in-year financial performance. The Committee noted that the delivery of savings within All Age Continuing Care remains a key risk within the programme.

Emerging demand and cost pressures

- Pressures identified in community reablement, pooled budgets and mental health packages, with unclear drivers partly due to delays in local authority reporting.

- Individual Patient Commissioning (IPC), including Continuing Care, remains off trajectory with limited financial improvement despite operational actions.

System-wide financial and workforce risk

- Provider organisations are reporting early financial deficits driven by industrial action and under-delivery of CIPs. The Committee noted that PWC remains engaged to scrutinise and challenge both provider and ICB financial performance.

- Workforce reduction plans across the system are likely to require non recurrent funding for implementation. Currently, this has not been identified.

Contracting and procurement progress

- Ongoing financial and contractual dispute with Mersey and West Lancashire NHS FT, with remaining gap (c£22.5m) and reliance on accessing ICB earmarked reserves. The Committee were assured that use of these reserves would be non-recurrent in nature.

- The Committee noted an historic use of procurement waivers, and this is now being more tightly controlled.

Strategic and governance gaps

- The Committee noted there is limited clarity and transparency on specialised commissioning expenditure (c£860m annually), requiring further breakdown and oversight at future meetings.

- The risk framework was discussed in detail including the need for it to be further developed and aligned to strategic objectives. The Committee discussed the need for a medium-term financial strategy aligned to the commissioning strategy.

Urgent and Emergency Care (UEC) delivery risk

- Delivery of UEC demand reduction plans subject to significant uncertainty, including funding risks (e.g. ED streaming tool), demand growth assumptions and early indication of performance risk.

Estates and capital utilisation risk

- Limited utilisation data for existing estate and reliance on alternative funding sources creates risk that investment decisions may not deliver optimal value.

Advise

Finance, Investment and Contracting Committee (FICC), 21st May 2026

Financial recovery

- Financial Recovery Programme has identified all required savings, with improved programme governance, SRO accountability and increased scrutiny is carried out through a series of committee deep dives.

- Recognition of need to improve scheme maturity, delivery confidence and phasing of savings.

Contracting and procurement progress

- Improved progress on contract negotiations, within the NHS (15 of 16 C&M providers agreed) and the independent sector (20 of 24 providers agreed).

- Increased maturity in procurement planning and decision tracking, with clear forward plan.

- Reinforcement of stricter waiver controls and compliance expectations.

CRES Deep Dive ADHD

- The committee were presented with a deep dive into the ADHD CRES programme for 26/27. which gave significant assurance on the work to date and plans for the year.

Capital and estate planning

- Progress in capital programme approvals and development of neighbourhood estate strategy under tight national timelines.

- Emphasis on understanding revenue consequences of capital investment.

External scrutiny and system alignment

- Ongoing oversight through NHSE FPRM and system delivery meetings, with increasing focus on:
    - Activity vs funding alignment
    - CIP delivery realism
    - Improvement in financial run-rate.

Finance, Investment and Contracting Committee (FICC), 17th June 2026

Financial Recovery

- Financial recovery programme maturing but capacity constrained.
- £153m of savings opportunities identified (against £144m target), demonstrating strong progress; however, programme delivery remains constrained by commissioning capacity and workforce challenges.

Demand Management

- Demand management and system transformation critical to sustainability.
- The UEC strategy was welcomed by the Committee. It was agreed that it provides a clear framework for demand reduction, but requires:
    - Stronger population health intelligence
    - Robust outcome measures
    - Alignment with financial modelling and system capacity
    - Stronger analytical capability and modelling.

Contracting and Procurement

- Significant progress in contracting and procurement discipline.
- Substantial progress has been made in formalising historic arrangements, including over 800 AACC contracts issued.
- The re-established Procurement Decision Review Group (PDRG) is strengthening oversight; however, continued reliance on waivers highlights capacity issues.

Strategic commissioning

- A shift towards intentional, value-based commissioning across NHS, independent and third sector providers is underway.

- Future opportunities identified across multiple service areas (e.g. ophthalmology, orthopaedics, community services), though delivery is resource constrained.

Better Care Fund

- Better Care Fund (BCF) requires strengthened governance and clarity.
- Current arrangements lack formal ICB governance and consistent system understanding, limiting transparency and effectiveness.
- The Committee supported transition to continuous assurance and development of an outcome framework.

Assure

Finance, Investment and Contracting Committee (FICC), 21st May 2026

Financial position and planning

- Month 1 position reported as balanced with a break-even forecast.
- Full CRES requirement identified early in the year, representing improved planning maturity.

Contracting progress

- Significant progress in agreeing provider contracts, providing improved system stability and planning certainty.
- Strengthened contract oversight arrangements to ensure activity and financial alignment.

Governance improvements

- Reinstatement of PDRG and clearer governance processes for procurement decisions.
- Strengthened oversight of procurement waivers and compliance processes.

Programme and transformation delivery

- ADHD programme demonstrating early success in reducing demand growth and improving care pathways.
- Financial Recovery Programme showing stronger governance and improved oversight compared to previous years.

Capital programme assurance

- Majority of capital schemes approved and progressing, aligned with strategic priorities.

External assurance

- Continued engagement with NHSE and PWC providing robust scrutiny and validation of financial plans and delivery.

Finance, Investment and Contracting Committee (FICC), 17th June 2026

Financial control and reporting

- Early-year financial position is reported as balanced, with established monitoring through Grip and Control and strengthened financial oversight.

- Positive external feedback has been received on financial planning and CRES identification through the FPRM process.

Contracting and governance improvements

- Significant assurance in the formalisation and rationalisation of contracts, reducing historic informality and improving compliance.

- Strengthened governance through PDRG and audit reporting of waivers.

CRES programme oversight

- Robust programme management arrangements are in place, including PMO assurance reporting and improved phasing visibility, providing greater transparency of delivery risk.

Strategic programme development

- The UEC strategy establishes a credible and system-wide framework for demand management and service transformation, aligned to long-term objectives.

Capital and estates

- Capital planning is progressing, with business cases in development; however, further assurance is required on estate utilisation and alignment to strategy.

Committee risk management

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

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
Financial Sustainability / Recovery	Ongoing oversight of CRES delivery, system financial pressures, and provider risks. Emphasis on strengthening grip and control, increasing maturity of CRES schemes, and aligning recovery actions to strategic programmes.

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
BAF risk P13	The Committee noted that risk articulation remains under development and requires strengthening to better reflect demand management, strategic risks, and medium-term financial planning. Greater clarity on controls, assurances and audit involvement is required.

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Financial planning and recovery	Oversight of Month 2 financial position, CRES delivery and financial recovery programme.
Contracting & Procurement	Near-complete contract sign-off; strengthened procurement governance and contract formalisation.
System Transformation	Development of UEC strategy and demand management approach.
Primary & Community Care	Oversight of AACC, IPC pressures and Better Care Fund governance reforms.
Strategic Commissioning	Progression of contracting and procurement review to support value-based commissioning.

Meeting of the Board of NHS Cheshire and Merseyside

30th July 2026

Integrated Performance Report

Agenda Item No:	**ICB/07/30/26/16**
Responsible Director:	**Jude Adams: Interim Executive Director of Strategy and Transformation (Turnaround)**

Integrated Performance Report

1. Purpose of the Report

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

2. Executive Summary

2.1 The integrated performance report for July 2026, see appendix one, provides an overview of key metrics drawn from the Operational plan, specifically covering Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, All Age Continuing Health Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance.

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

2.3 The report has been enhanced as part of a wider piece of work to review the metrics, with the aim of providing clear assurance against statutory duties and strategic priorities. The design of this report is a hybrid of the existing and new formats and aligns more closely with best practice and has been made clearer where performance is not achieving plan.

2.4 A considerable number of new metrics were recommended for inclusion following discussions with Exec Directors, Non-exec directors and subject matter experts from within the ICB. A working group was established to consider these, and some have been included in the report. The next version of the IPR will include all new metrics and these will be aligned to the 'life-course' framework.

2.5 The enhanced report includes a traditional executive summary and also a summary against our 'life-course' framework for consideration and feedback

3. Ask of the Board and Recommendations

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

4. Reasons for Recommendations

4.1 The report is sent for assurance.

5. Background

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

Implications and Comments

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

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

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

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

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

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

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

8. Link to meeting CQC ICS Themes and Quality Statements

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

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

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

9. Risks

9.1 The report provides a broad selection of key metrics and identifies areas where delivery is at risk. Exception reporting identifies the issues, mitigating actions and delivery against those metrics which also links to the Board Assurance Framework.

10. Finance

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

11. Communication and Engagement

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

12. Equality, Diversity and Inclusion

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

13. Climate Change / Sustainability

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

14. Next Steps and Responsible Person to take forward

14.1 Actions and feedback will be taken by Jude Adams, Interim Executive Director of Strategy and Transformation. Actions will be shared with, and followed up, by relevant teams. Feedback will support future reporting to the ICB Board.

15. Officer contact details for more information

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

16. Appendices

Appendix One: Integrated Quality and Performance report

NHS
Cheshire and Merseyside

Integrated Performance Report

ICB Board

30th July 2026

Contents

Executive Summary

Areas showing improvement

- **Urgent and Emergency Care is showing early signs of recovery**, with A&E performance remaining stable, ambulance handover performance improving from winter levels, and continued focus on discharge and patient flow across the system.
- **Elective recovery continues to make strong progress**, with sustained reductions in long waits, including further reductions in CYP 52-week waits and significant backlog clearance across elective pathways.
- **Cancer performance remains strong relative to England**, with 62-day performance continuing to outperform the national average and delivery remaining broadly on track towards year-end trajectories.
- **Faster Diagnosis Standard performance has improved significantly year-on-year**, providing confidence in recovery towards the 80% standard despite short-term variance to plan.
- **Mental health access continues to improve**, with Talking Therapies long waits more than halved over the past year through targeted backlog reduction and service improvement activity.
- **Learning Disability and Autism inpatient numbers continue to reduce**, supported by sustained discharge activity and improved national quartile performance.
- **Population health outcomes show positive progress**, including improving smoking prevalence, hypertension control and cholesterol management through targeted prevention programmes.
- **The ICB remains financially on plan**, reporting a breakeven position year to date and continuing to forecast delivery of its planned year-end financial position.

Areas of concern

- **System flow and capacity pressures continue to impact urgent and emergency care performance**, with A&E performance below target and 12-hour waits remaining significantly above plan, driven by delayed discharges and constrained inpatient capacity.
- **Patients no longer meeting the criteria to reside remain a major system challenge**, with over one in five acute beds occupied by patients awaiting onward care, limiting capacity and affecting wider system performance.
- **Diagnostic performance remains off trajectory**, particularly within endoscopy services, where workforce shortages, capacity constraints and underperformance within some independent sector providers continue to impact delivery.
- **NHS dental access remains below target**, reflecting ongoing challenges in improving access to routine NHS dental care across Cheshire and Merseyside.
- **Children and young people's elective waits remain above national standards**, with performance risk concentrated within a small number of providers, particularly Alder Hey.
- **Mental health outcomes remain mixed**, with physical health checks for people with severe mental illness below target and Talking Therapies recovery outcomes continuing to show unwarranted variation.
- **Quality concerns persist at East Cheshire**, which remains an outlier for mortality performance with SHMI above the expected range and subject to enhanced oversight.
- **Delivery of the £155.4m efficiency programme remains a key risk**, with reliance on significant second-half-year delivery.

Headlines by life course (1)

Starting Well

Areas of concern

Limited assurance available as key performance narratives and exception reporting are not yet fully populated

Areas showing improvement

Domain metrics and narratives remain under development

Growing Well

Areas of concern

CYP 52 week waits remains above national standard

Sustained recovery will be required to eliminate remaining long waits

Areas showing improvement

Continued reduction in CYP 52 week waits

Elective recovery actions and additional capacity supporting reductions

Data quality and forecasting arrangements have improved

Living Well

Areas of concern

Diagnostic performance remains below national ambition

Workforce shortages and capacity limitations continue to constrain delivery

NHS Adult dental access remains below target

Areas showing improvement

Endoscopy performance showed improvement across all major tests

Record utilisation of the Endoscopy Hub and increased referrals supporting recovery efforts

System wide recovery plans have been implemented across providers

Headlines by life course (2)

Living Healthy Lives

Areas of concern

62-day and 28-day FDS performance below planned trajectories

Variation in smoking prevalence remains evident across places

Further improvement required in prevention and screening update to reduce inequalities

Areas showing improvement

Cancer 62-day target above England average and on track to achieve target

FDS performance improved compared with last year

Ongoing investment in population health programme is supporting healthier lifestyles and reducing inequalities

Ageing Well

Areas of concern

A&E 4-hour target remains below target and 12-hour waits above target

More than 20% of beds are occupied by patients no longer meeting criteria to reside, constraining capacity

Delayed discharges, frailty demand and limited inpatient capacity continue to impact UEC performance

Areas showing improvement

Despite operational pressure, A&E 4-hour performance remains broadly stable

System partners continue to strengthen discharge processes, patient flow and bed utilisation

Dying Well

Areas of concern

ECT remains a mortality outlier with SHMI above expected range and increasing

Higher than expected deaths occurring within 30 days of discharge require ongoing oversight

Sustained quality improvement action required to address the underlying drivers

Areas showing improvement

System wide mortality performance remains within expected levels across majority of providers

Enhanced governance and quality improvement activity in place to support recovery at ECT

Starting Well

Starting Well

Starting Well - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
Still birth per 1,000 (rolling 12 months)	May-26	2.70	2.60				n/a	3.80	n/a
Pre Term Births (NEW)	May-26	130	TBC			n/a	n/a	n/a	n/a
Breast Milk at First Feed % (NEW)	May-26	66.8%	TBC			n/a	n/a	n/a	n/a

Growing Well

a) 52 week waits for CYP

Growing Well

Growing Well - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
Number of 52+ week RTT waits, of which children under 18 years.	May-26	451	0				n/a	n/a	n/a
Number of unique patients seen by an NHS Dentist – Children (12 month)	May-26	343,143	337,612				1,054,212	7,365,400	n/a

CYP 52-week waits

NHS
Cheshire and Merseyside

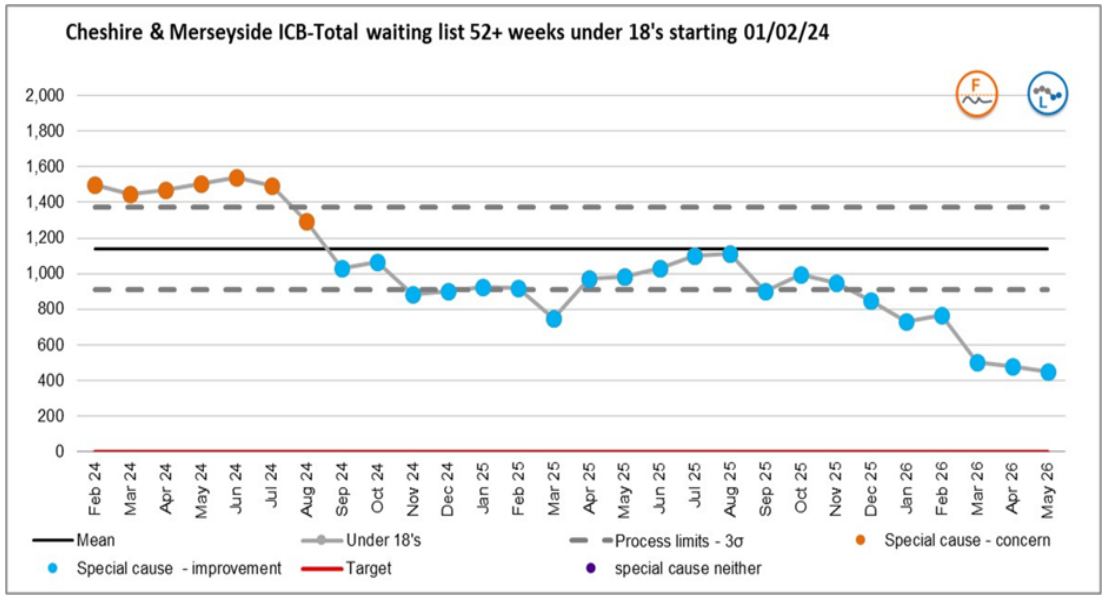
Outcome:

No patient should wait longer than 52 weeks for elective treatment, supporting timely care and better long-term outcomes

Measure of Progress:

Eliminating the children and young people under 18 waiting in excess of 52 weeks for elective care. The target for this metric is zero

Executive Lead: Jude Adams



Number of 52+ week RTT waits, of which children under 18 years

Issue

- There were 451 CYP patients waiting 52 weeks+ at May 2026 month end, an **improvement on previous months**, though performance **remains above the national standard** of zero.
- The largest proportion is at Alder Hey Children's Hospital (190), indicating concentration of risk at a single provider.
- Data quality and forecasting have previously limited planning and assurance, although improvements have been delivered across all providers.

Action

- Six Trusts remain in NHSE Tiering with improvement plans and regular oversight. The CMPC Elective team holds fortnightly reviews with providers to monitor performance and support delivery of recovery actions.
- The C&M Q4 plan, supported by additional NHSE funding, is increasing clinical triage of patients waiting over 27 weeks, delivering **20–30% pathway removals** and supporting progress against the 52-week standard.
- A System Capacity Management Process is being implemented to optimise elective hub utilisation and enable inter-provider support, alongside additional regional funding to increase capacity and reduce long waits and overall waiting list size.

Delivery

- Delivery is overseen through the C&M Clinical Operational Group, with progress monitored via CMPC COO Group and Delivery Board, ensuring ongoing oversight, accountability, and trajectory management.

Living Well

a) Diagnostics
b) NHS Dentist Adult Access

Living Well

Living Well - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
The % of people waiting less than 18 weeks on the waiting list (RTT)	May-26	65.2%	63.7%				64.7%	65.6%	20/36
The % of people waiting more than 52 weeks on the waiting list (RTT)	May-26	1.2%	1.4%				1.4%	1.4%	19/36
Patients waiting more than 6 weeks for a diagnostic test	May-26	12.4%	10.4%				13.9%	24.0%	5/36
Number of unique patients seen by an NHS Dentist – Adults (24 month)	May-26	954,715	963,452				2,687,769	18,399,528	n/a
% of urgent GP appointments seen within 24 hours (NEW)	May-26	79.0%	76.7%				n/a	n/a	n/a
Percentage of ICB inappropriate out of area placement bed days in Adult acute beds	Apr-26	2.0%	0.0%				1.6%	2.1%	28/42

Diagnostic waits >6 weeks

NHS Cheshire and Merseyside

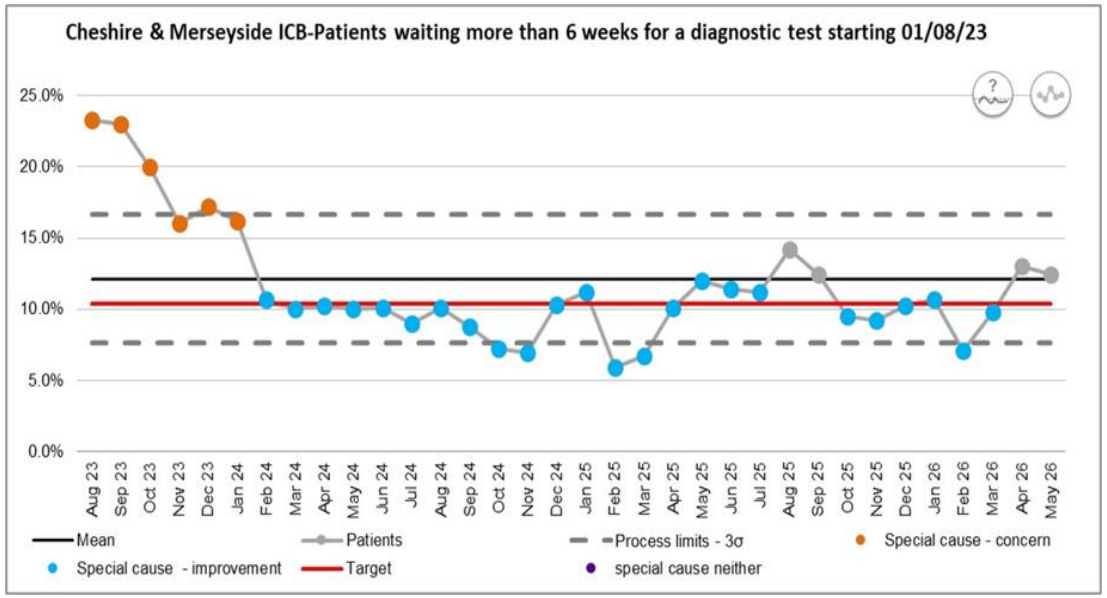
Outcome:

Patients receive timely access to diagnostic tests, enabling faster diagnosis, earlier treatment and improved clinical outcomes

Measure of Progress:

A reduction in the % of patients waiting over 6 weeks from referral to a diagnostic test. There are monthly trajectories towards the end of year target of 5.7%

Executive Lead: Jude Adams



Patients waiting more than 6 weeks for a diagnostic test

Issue

- Endoscopy performance (gastroscopy, colonoscopy, flexi-sigmoidoscopy) remains a **system-wide issue** despite performance improvements to all 3 Endoscopy tests in May. This has been driven by reduction in admin and booking staff, scoping workforce shortages and increased sickness absences, recruitment constraints, reduced and complete cessation of premium spend activity, decontamination issues, theatre capacity and competing priorities for Endoscopy unit resource.
- **Independent Sector Provider performance** at 78.6% seen within 6 weeks (those Providers holding a contract with the ICB through AQP) **remains significantly lower than NHS Provider performance** at 87.8% seen within 6 weeks. This is prevalent across Endoscopy tests, particularly at **Community Health and Eye Care LTD.** This continues to be escalated to the ICB Contracts team.

Action

- **System Endoscopy Recovery Plan** endorsed at Diagnostic Delivery Board on 19/07, to be taken through COOs Group for further endorsement.
- All Providers have now submitted Endoscopy Recovery Plans with accompanying performance trajectories, these are being **monitored and tracked through regular Diagnostic PTL Meetings** with Providers.
- Ongoing work to **fully maximise Endoscopy Hub capacity which remains underutilised**, all Providers referring into the Hub with a **record number of referrals sent in June**. Pilot with MWL underway to refer patients at the beginning of their waiting list journey.
- **Gastroscopy <55 years old** prioritised as part of the **Right Test, Right Time** project with an immediate focus (circa 40% of C&M Gastroscopy waiting list is under the age of 55 years) with clinical review and validation of this patient cohort to commence.

Delivery

- The system is working toward **delivery of the 96.6% diagnostic standard by March 2027**, with focus on increasing capacity, improving utilisation, and mitigating demand pressures.

NHS Dentist Adult Access

NHS Cheshire and Merseyside

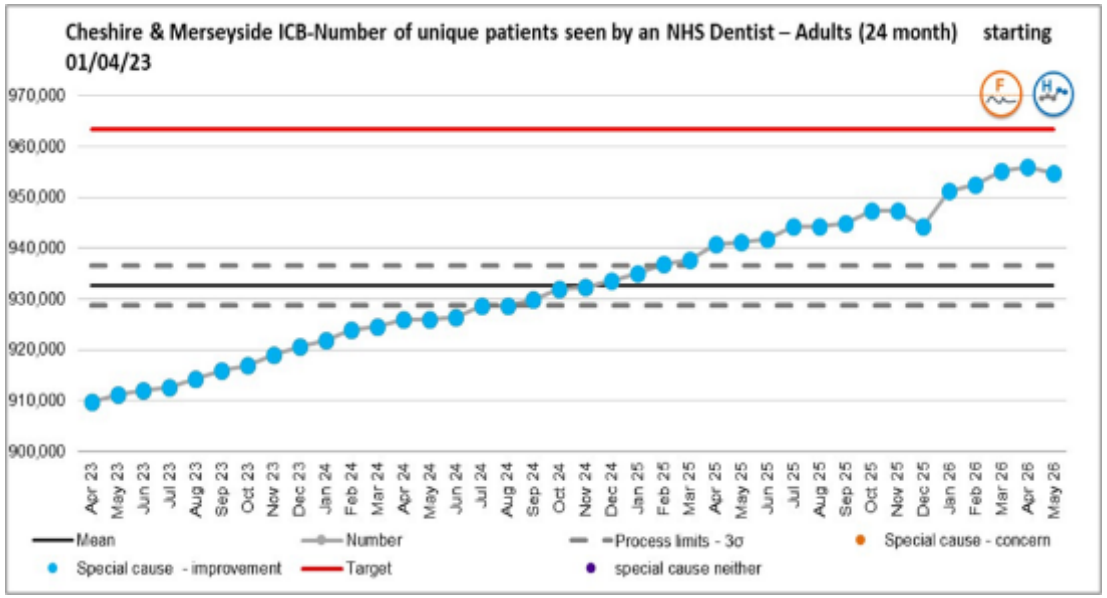
Outcome:

More adults are able to access NHS dental care

Measure of Progress:

An increase in the number of unique adult patients who have received NHS dental care within the last 12 months

Executive Lead: Clare Watson



Number of unique patients seen by an NHS Dentist – Adult (12 month)

Issue

- C&M is **not currently meeting the target** for the number of unique adult patients seen by an NHS dentist over a 12-month period, indicating continued challenges in access to NHS dental services.

Action

- National data is now available to commissioners and is being used to review the impact of **primary care contract reforms introduced from 1 April**, with a focus on improving access.
- The ICB continues to invest in the **Quality and Access Scheme** and the **Neighbourhood Dental Pilot**, both of which provide access for patients who do not have a regular NHS dentist. Additional funding has been identified to commission further activity through to the end of 2026/27 and build on existing schemes.
- A **Practice Sustainability Framework** is being introduced to support practices experiencing delivery challenges, enabling activity to be redistributed where appropriate to maximise access across the system.

Delivery

- Analysis of BSA data is ongoing to assess the impact of contract reforms on patient access.
- The ICB continues to work closely with **Local Dental Committees** to support practice delivery and sustainability.
- Commissioners are developing an **additional activity plan for the remainder of 2026/27**, with the aim of increasing access and improving performance against the target.

Living Healthy Lives

a) Cancer 62-day
b) Cancer 28-day FDS
c) Smoking
d) Cervical Screening Rate
e) Breast Screening Rate
f) MMR Uptake

Living Healthy Lives

Living Healthy Lives - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assurance	Plan Met	Region Value	National Value	ICB Rank
2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	May-26	74.4%	75.7%		?	✗	n/a	69.6%	n/a
Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	May-26	78.9%	80.9%	H	F	✗	n/a	79.0%	n/a
Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems. (Aged 15+)	Jun-26	15.9%	12.0%	L	F	✗	0.0%	12.7%	n/a
Cervical Screening Rate (NEW)	May-26	68.3%	80.0%	L	F	✗	0.0%	0.0%	n/a
Bowel Screening Rate (NEW)	May-26	69.4%	62.0%	H	P	✓	0.0%	0.0%	n/a
Breast Screening Rate (NEW)	May-26	69.3%	70.0%	H	F	✗	0.0%	0.0%	n/a
MMR Uptake (2 doses by fifth birthday) (NEW)	Q4 25/26	83.1%	95.0%	L	F	✗	84.6%	84.1%	34/42

Cancer 62-day waits

NHS Cheshire and Merseyside

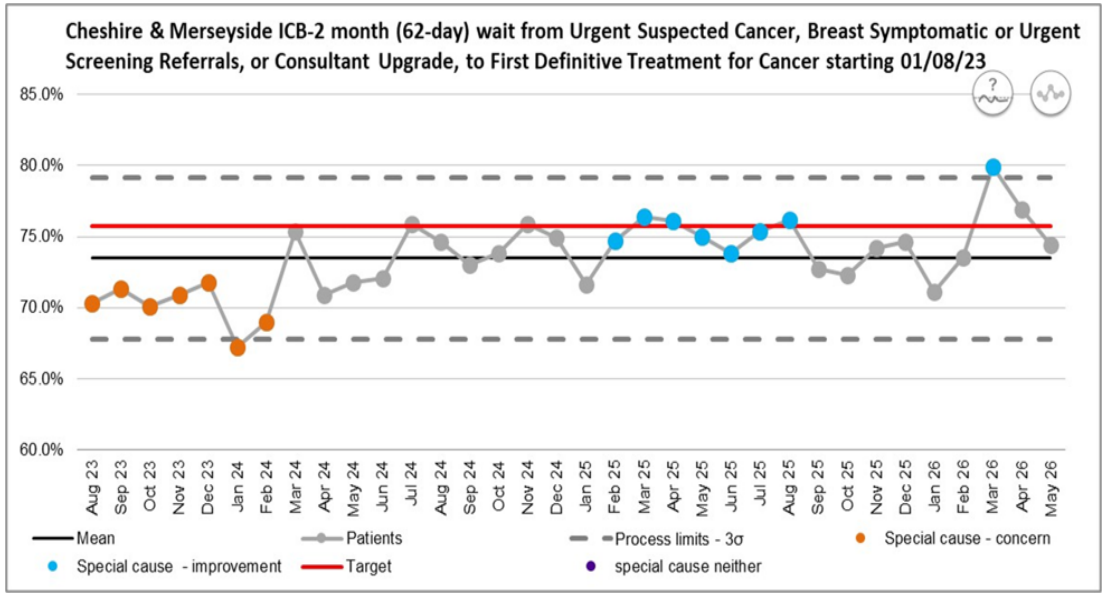
Outcome:

Patients referred urgently with suspected cancer start their first definitive treatment within 62 days of referral, improving outcomes and patient experience

Measure of Progress:

An increase in the % of patients who commence first definitive treatment for cancer within 62 days of an urgent suspected cancer referral.

Executive Lead: Fiona Lemmens



2 month (62-day) wait for First Definitive Treatment for Cancer

Issue

- C&M is **1.3% behind plan** for the 62-day cancer standard in May 2026. However, performance remains strong overall and is delivering at a higher level than the national position.

Action

- The C&M trajectory sets out an improvement from **75.4% to 80% by year end**. Performance was **1.5% ahead of plan in April 2026** and slightly below plan in May but remains broadly on track to achieve the year-end target.
- C&M continues to outperform England, delivering approximately **7% above the national position in April** and **5% above in May**.
- Monthly performance forums will continue throughout 2026/27, with targeted pathway transformation programmes in **lung, skin, gynaecology, breast, and lower GI cancers** supporting further improvements in 62-day performance.

Delivery

- C&M remains on track to achieve the **80% year-end target** and is expected to continue performing significantly above the England average.

Cancer 28-day FDS

NHS
Cheshire and Merseyside

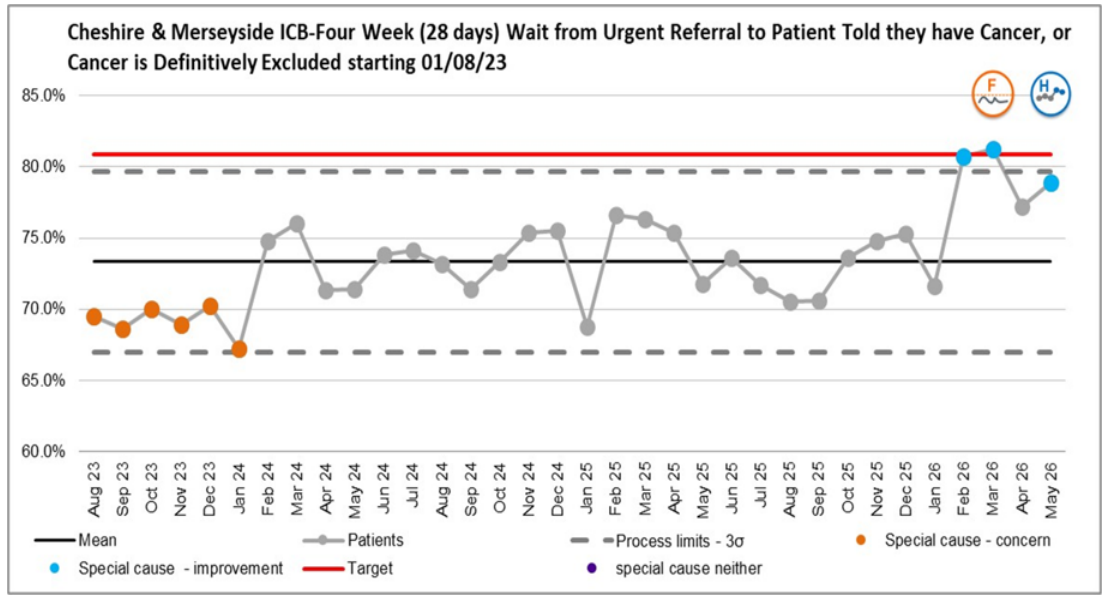
Outcome:

Patients are told whether they have cancer, or cancer is ruled out, within 28 days of an urgent referral

Measure of Progress:

An increase in the % of patients referred urgently for suspected cancer who receive a definitive diagnosis or have cancer ruled out within 28 days. The target is 80% as an average throughout the financial year

Executive Lead: Fiona Lemmens



Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded

Issue

- The ICB is currently **2.4% behind the year-to-date planned trajectory** for the 28-day Faster Diagnosis Standard (FDS).

Action

- CMCA continues to lead delivery of the FDS through **monthly performance forums with providers**, supporting improvement through pathway transformation, operational oversight, and targeted investment.
- Despite the current variance to plan, performance has improved significantly year on year, with April 2026 performing 5.4% above April 2025 and May 2026 performing 5.3% above May 2025.
- This sustained improvement provides confidence that performance can return to the **80% standard** in the coming months.
- To mitigate anticipated seasonal pressures, CMCA has coordinated and supported **business continuity plans for skin cancer services**.

Delivery

- Whilst there is a risk of some deterioration over the summer period, this is reflected within planned trajectories. Overall, performance is expected to recover to the **80% standard**, supported by continued pathway improvement and provider oversight.

Smoking

NHS
Cheshire and Merseyside

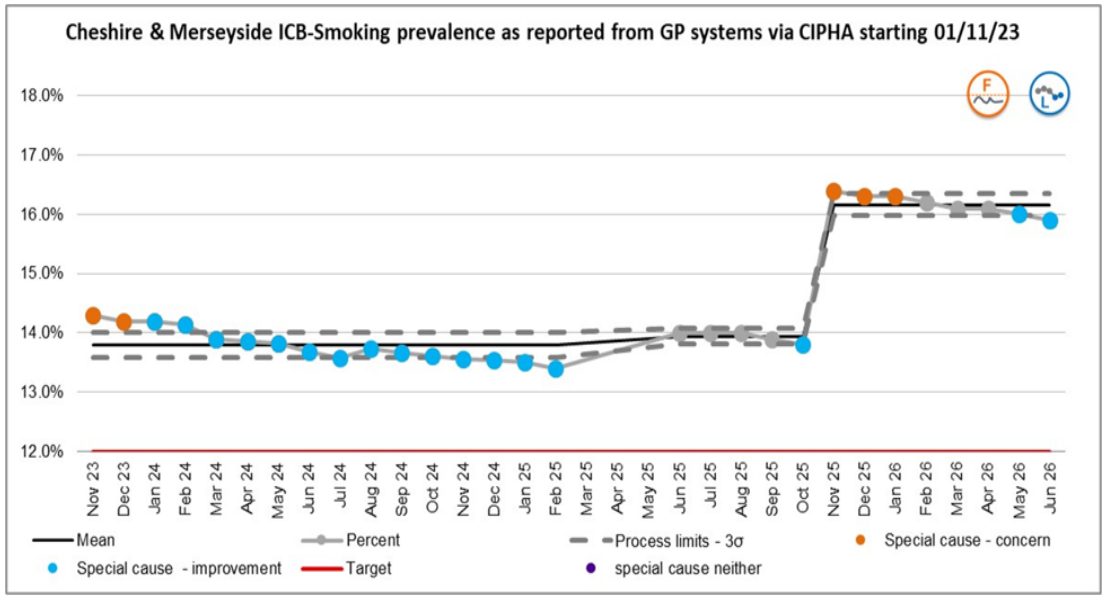
Outcome:

Fewer people are recorded as current smokers in GP systems, reflecting successful prevention, cessation support and improved public health

Measure of Progress:

A reduction in the % of patients registered on GP systems who are recorded as current smokers

Executive Lead: Clare Watson



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

Issue

- Reducing smoking prevalence remains the single greatest opportunity to tackle health inequalities and improve healthy life expectancy across C&M.
- Progress is being made; however, **variation across Places and smoking prevalence rates remain key challenges**, with further reductions required to improve population health outcomes.

Action

- A system review has identified a number of priority actions, including improving the consistency and uptake of Very Brief Advice (VBA) training across health professionals, building on learning from a pilot in a Cheshire West and Chester PCN.
- Additional actions include strengthening **referral pathways between community mental health services and community smoking cessation services**.
- Work is underway with the **National Centre for Smoking Cessation and Training (NCSCT)** to develop a self-assessment and service improvement tool, enabling both the ICB and provider Trusts to identify and prioritise areas for improvement within NHS Tobacco Dependency services.
- A targeted digital campaign aimed at **18–30-year-old light and social smokers** launched on 20 July and will run for six weeks. This is supported by targeted engagement activities at events across Cheshire and Merseyside to promote smoking cessation support and the *Smoking Ends Here* website.

Delivery

- Performance is expected to **continue improving**, although reductions in smoking prevalence are likely to be **gradual**, with ongoing variation across Places.
- Ensuring consistent access to **evidence-based smoking cessation support** remains a key priority, supported by workforce development, service improvement activity, and targeted population campaigns.
- Sustained delivery across all providers will be required to achieve further reductions in smoking prevalence and narrow health inequalities.

*The methodology for calculating smoking prevalence has changed from April 2025 we are now using the registered population aged 15+ as the denominator

Cervical Screening Rate

NHS Cheshire and Merseyside

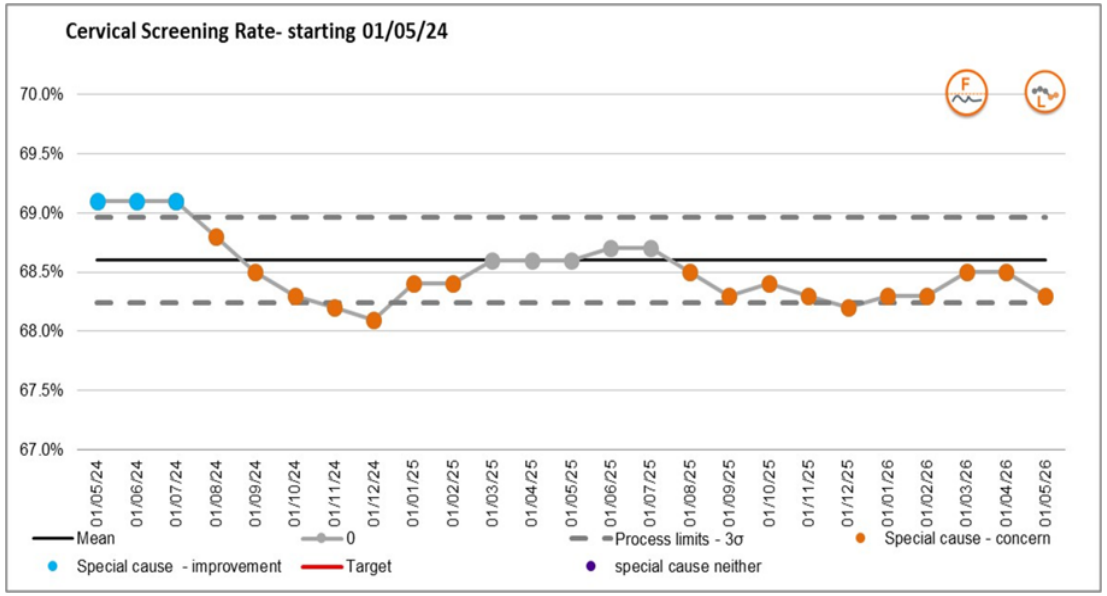
Outcome:

Eligible individuals participate in cervical screening at recommended intervals, enabling early detection and prevention of cervical cancer.

Measure of Progress:

An increase in the % eligible individuals who have had an adequate cervical screening test within the recommended screening interval.

Executive Lead: Fiona Lemmens



** Commissioning responsibility for this metric is with our NHSE NW team, however from April 2027, this will be transferred to the ICB*

Cervical Screening Rate *

Issue

- Cervical screening coverage remains **below the national programme standard**, with uptake plateauing at approximately **68–69%**.
- Significant variation persists across Places and population groups, particularly within **underserved communities and areas of higher deprivation**. Missed opportunities remain to engage eligible individuals who do not routinely attend screening, while workforce and appointment capacity pressures continue to affect access in some areas.

Action

- A Cheshire and Merseyside-wide **cervical screening improvement programme** has been established, informed by patient and public insight.
- Partners are implementing initiatives to improve access, flexibility, patient experience, communications, and workforce capability, with a particular focus on reducing inequalities and increasing uptake among underserved groups.
- Alternative delivery models are being tested and expanded, including community sexual health services, workplace screening initiatives, and mobile outreach programmes. The Living Well Bus cervical screening service has been a key component of this approach, helping to extend access into communities with historically lower uptake.

Delivery

- Delivery has increased access to cervical screening through a wider range of settings and targeted interventions focused on underserved populations.
- The **Living Well Bus** has engaged almost 3,000 individuals and completed more than 2,200 cervical screens, with around **50% of those screened previously identified as non-responders** and **18% attending their first-ever cervical screening appointment**. The service has successfully reached residents in the most deprived communities and achieved a **98% recommendation rate** from service users.
- There is evidence of improved engagement with previously non-responsive groups, supported by stronger partnership working across NHS organisations, local authorities, primary care, sexual health services, and community partners.
- These interventions support the NHS ambition of **eliminating cervical cancer by 2040**, with continued focus on increasing uptake, reducing inequalities, and improving screening coverage across Cheshire and Merseyside.

Breast Screening Rate

NHS Cheshire and Merseyside

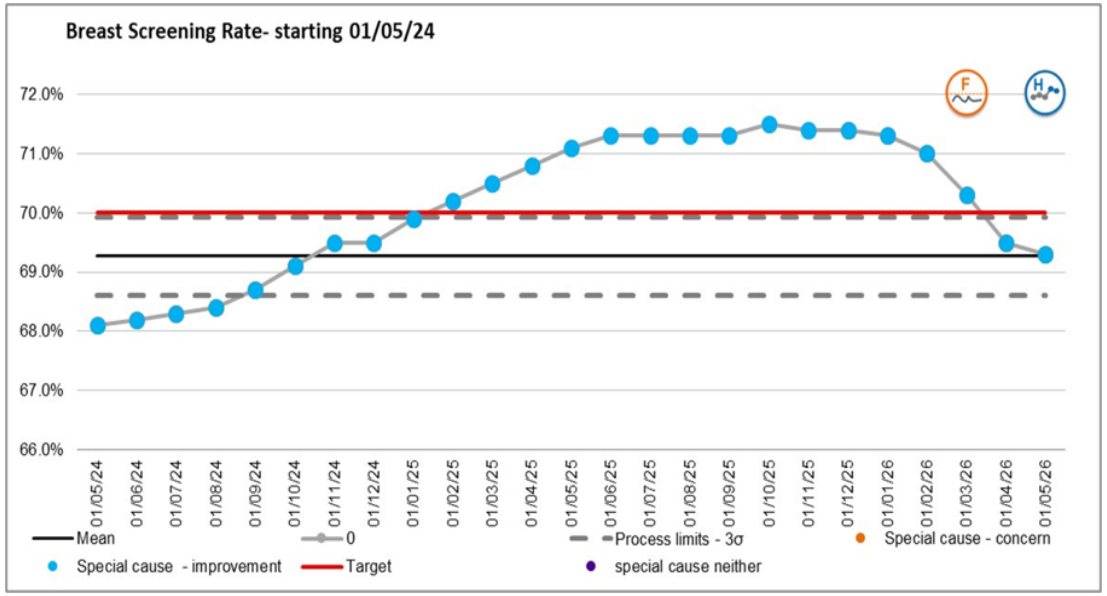
Outcome:

Eligible individuals attend routine breast screening, enabling earlier detection of breast cancer and improving long-term health outcomes

Measure of Progress:

The percentage of eligible individuals who have undergone breast screening within the recommended screening interval.

Executive Lead: Fiona Lemmens



** Commissioning responsibility for this metric is with our NHSE NW team, however from April 2027, this will be transferred to the ICB*

Breast Screening Rate *

Issue

- Breast screening uptake remains **below optimal levels**, with variation in participation across Places and population groups.
- Persistent inequalities exist in attendance rates, particularly among underserved communities and first-time invitees, limiting equitable access to early diagnosis. Patient feedback also highlights the importance of accessible appointments, positive experiences, and timely diagnostic pathways in supporting participation.

Action

- C&M has established a **system-wide breast screening improvement programme** focused on increasing uptake, reducing inequalities, and improving patient experience.
- Dedicated **Improving Uptake Workers** have been deployed across screening services, with a growing focus on supporting first-time invitees and populations less likely to attend.
- Providers are expanding access through more flexible appointment options, including early morning, evening, and weekend clinics, alongside targeted engagement and communications campaigns.
- Close collaboration between screening, diagnostic, and cancer services is supporting pathway improvements and ensuring patient feedback directly informs service development.

Delivery

- C&M's approach to improving participation has been **recognised nationally as an example of good practice**, with recurrent investment secured to sustain and expand successful uptake initiatives.
- The impact of targeted improvement work is already being demonstrated. Within the **Wirral and Chester Breast Screening Programme**, all targeted GP practices achieved an increase in uptake compared with the previous screening round. The lowest-performing practice improved from 43% to 67% uptake, while **six of twelve practices now exceed the 70% acceptable uptake threshold**, with **a further practice exceeding the 80% achievable threshold**.
- Increased focus on first-time attendees, patient experience, and flexible access is supporting earlier diagnosis and helping to reduce inequalities in participation. Stronger partnership working across screening, diagnostics, and cancer services continues to support a more responsive and person-centred pathway.

MMR Uptake

NHS Cheshire and Merseyside

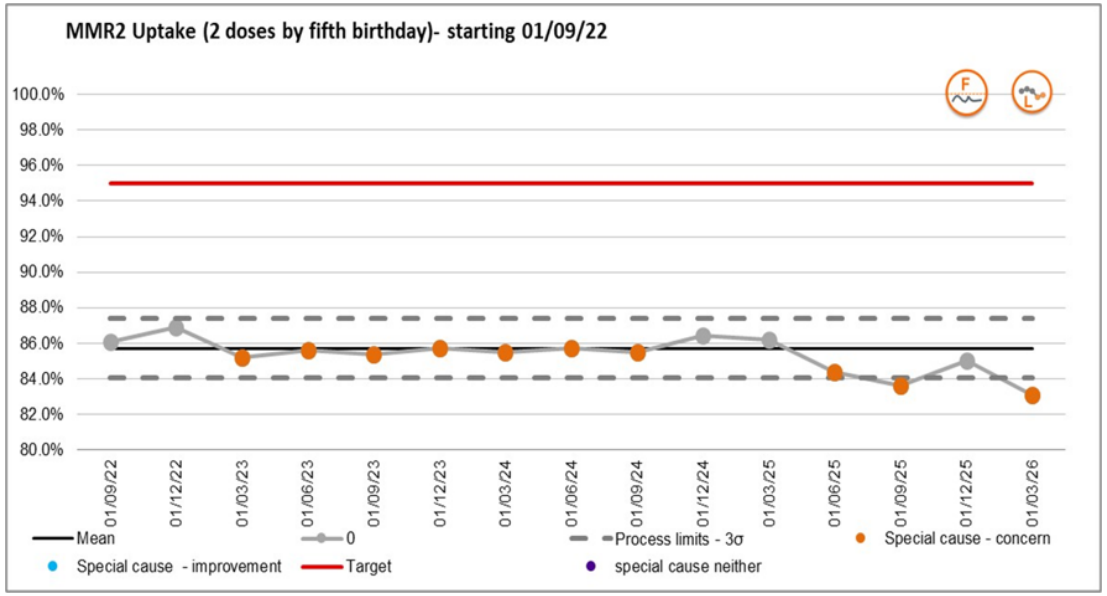
Outcome:

Eligible children receive both recommended doses of the MMR vaccine, reducing the risk of disease outbreaks and protecting population health

Measure of Progress:

An increase in the % of eligible children who have received the recommended MMR vaccination(s) by a specified age.

Executive Lead: Fiona Lemmens



** Commissioning responsibility for this metric is with our NHSE NW team, however from April 2027, this will be transferred to the ICB*

MMR Uptake (2 doses by fifth birthday) *

Issue

- MMR uptake remains **below the 95% level required for population protection**, increasing the risk of measles outbreaks and exacerbating health inequalities.
- Variation in uptake persists across Places, communities, and population groups, with lower vaccination rates concentrated within some underserved populations. Vaccine confidence, access barriers, and missed opportunities to vaccinate continue to contribute to suboptimal coverage.

Action

- C&M has established a **multi-agency vaccination partnership**, bringing together NHS, local authority, education, and provider partners to coordinate action and improve immunisation uptake, including MMR vaccination.
- Focused work is underway to **improve school readiness**, identify unvaccinated children earlier, and maximise catch-up opportunities through primary care and school-aged immunisation services.
- Additional Place-based investment is supporting targeted interventions in areas with lower uptake and higher levels of need. Population health intelligence is being used to identify variation and enable **locally tailored approaches** to improving vaccination coverage.

Delivery

- System teams are working directly with **primary care, schools, local authorities, and community partners** to identify and vaccinate children who remain unprotected. Targeted catch-up initiatives are increasing opportunities for vaccination through school and community settings, while community engagement and outreach programmes are addressing barriers to access and supporting underserved groups.
- This targeted approach is already demonstrating impact. In Sefton, additional locality investment supported a **Child Immunisation Project** focused on families least likely to access routine vaccination services. Working with GP practices and parents, the project prioritised children from deprived communities, newly arrived families, and those with incomplete vaccination histories. As a result, 515 children have been vaccinated, delivering 1,402 childhood immunisations, including targeted MMR catch-up activity. Home visits and tailored support have further improved access for children with additional needs and families facing barriers to vaccination.
- A sustained focus on school readiness, targeted outreach, and catch-up vaccination is expected to improve coverage, reduce inequalities, and lower the risk of future outbreaks.

Ageing Well

a) A&E 4-hour waits
b) A&E 12-hour waits
c) NCTR

Ageing Well

Ageing Well - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
4-hour A&E waiting time (% waiting less than 4 hours)	Jun-26	73.2%	78.2%				72.9%	75.0%	24/36
A&E 12 hour waits from arrival (Type 1 & 2)	Jun-26	17.3%	15.6%				13.1%	9.7%	34/36
Percentage of beds occupied by patients no longer meeting the criteria to reside (Rolling 7-day average last week of month)	Jun-26	20.2%	TBC			n/a	n/a	n/a	n/a
Percentage of people who are discharged from acute hospital to their usual place of residence (NEW)	Feb-26	82.2%	0.0%				0.0%	81.0%	n/a
Reduction in emergency admissions for people aged 65+ (NEW)	May-26	11,608	11,922				n/a	n/a	n/a
Reduction in non-elective admissions for patients with frailty (10% reduction against baseline) (NEW)	May-26	5,284	4,874				0	0	n/a
% CRFD in Mental Health Inpatient beds (NEW)	TBC		0.0%				0.0%	0.0%	n/a

A&E 4-hour & 12-hour waits

NHS Cheshire and Merseyside

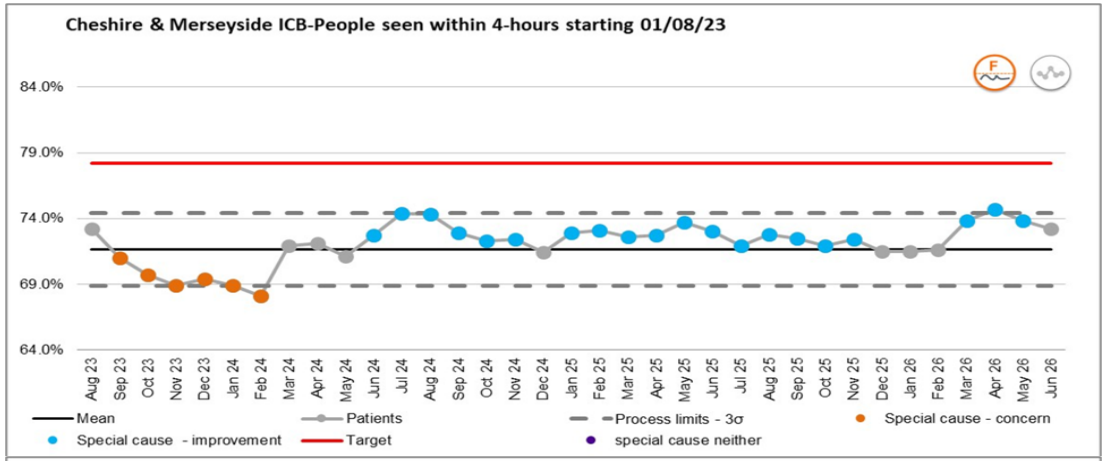
Outcome:

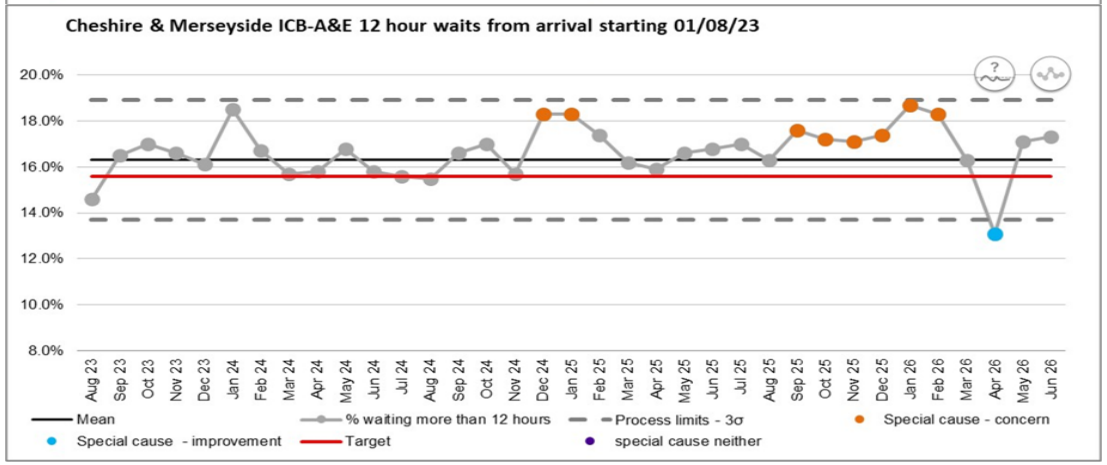
Patients receive timely assessment, treatment and admission/discharge from ED & elimination of long waits to improve safety and experience

Measure of Progress:

An increase in emergency department (ED or A&E) performance towards overall 4-hour target of 85%. We aim for an interim trajectory of 82% by March 2027

Executive Lead: Jude Adams





A&E 4-hour & 12-hour waits

Issue

- Cheshire and Merseyside ICB continues to **underperform against the A&E 4-hour standard** and remains challenged by **high levels of 12-hour waits from arrival**, reflecting ongoing flow and discharge pressures across the urgent and emergency care pathway.
- A&E 4-hour performance is **73.2% against the 78.2% target**. While performance has remained relatively stable over the past 12 months and is marginally above the regional average (72.9%), it remains below the national ambition. A key constraint is system flow, with **20.2% of beds occupied by patients who no longer meet the criteria to reside**, reducing capacity for emergency admissions and slowing movement through Emergency Departments.
- A&E 12-hour waits from arrival remain a significant concern at **17.3% against a target of 15.6%**. Performance demonstrates sustained special cause variation since late 2025, indicating a systemic issue rather than short-term fluctuation. The main drivers are limited inpatient capacity, discharge delays, and increasing complexity of frailty and urgent care demand.

Action

- System partners continue to prioritise **improvements in patient flow, discharge performance, and bed utilisation** to support recovery of both 4-hour and 12-hour performance measures.
- Targeted operational actions focus on reducing the number of patients not meeting the criteria to reside, improving discharge timeliness, and increasing available inpatient capacity for emergency admissions.
- Ongoing oversight is provided through established urgent and emergency care governance arrangements, with performance monitored against regional and national benchmarks.

Delivery

- Based on current performance, delivery of the 78.2% A&E 4-hour standard **is unlikely in the short term**, however, further incremental improvement is anticipated as discharge performance and bed utilisation improve.
- Recovery in **12-hour waits is expected to be slower**, given the scale of the challenge and its dependence on sustained improvements in inpatient capacity, discharge timeliness, and reductions in delayed discharges. Achievement of the target is dependent upon significant reductions in bed occupancy and frailty-related demand pressures.

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NCTR

NHS
Cheshire and Merseyside

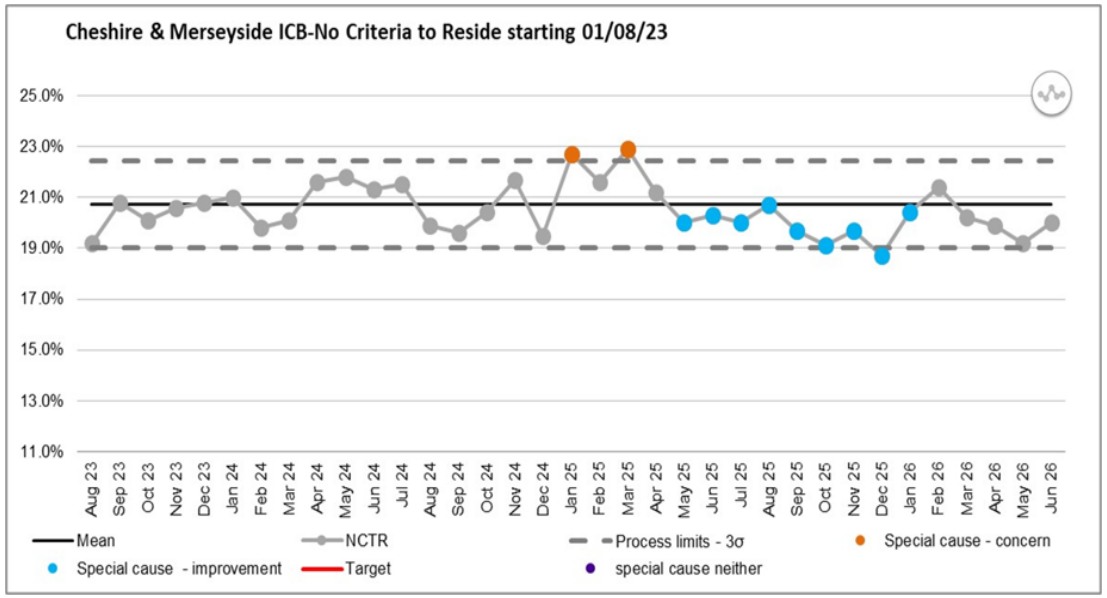
Outcome:

Patients are cared for in the most appropriate setting without delay

Measure of Progress:

A reduction in the % of patients remaining in hospital who do not require to be in hospital.

Executive Lead: Jude Adams



Percentage of beds occupied by patients no longer meeting the criteria to reside

Issue

- The proportion of beds occupied by patients who no longer meet the criteria to reside **remains high at 20.2%**, continuing to constrain hospital capacity and impact patient flow across the urgent and emergency care pathway.

Action

- Performance remains above the desired level, although 2025 saw a sustained period of improvement, with several months showing performance below the historical average. More recent deterioration suggests these improvements have not yet been consistently embedded across the system.
- Variation between providers continues to influence the overall ICB position. Acute sites with higher levels of delayed discharge remain a key focus, with targeted actions to reduce delays associated with **assessment processes, care package provision, rehabilitation capacity, and placement availability**.
- Reducing the number of patients who no longer meet the criteria to reside remains a **critical system priority**, supporting improvements in emergency department flow, ambulance handovers, elective recovery, and overall bed availability. The SCC continues to oversee these actions on a daily basis.

Delivery

- Performance is expected to remain around current levels in the short term, with **gradual improvement anticipated during 2026/27** as discharge capacity and community support arrangements strengthen.
- While the system has demonstrated that lower levels can be achieved, sustained improvement will require **consistent reductions in discharge delays and improved access to onward care pathways**.
- There remains a risk that performance could stabilise above the historical average unless current improvement actions are accelerated. Subject to successful implementation of discharge and community capacity initiatives, a reduction to **below 20% within the next 6–12 months** is considered achievable.

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Dying Well

a) SHMI

Dying Well

Dying Well - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
Reduction in the proportion of our population dying in hospital - All ages (NEW)	May-26	47.0%	49.1%				n/a	42.8%	n/a
Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation	Feb-26	1.000	0.887 to 1.127			n/a	0.000	1.000	n/a

SHMI

NHS
Cheshire and Merseyside

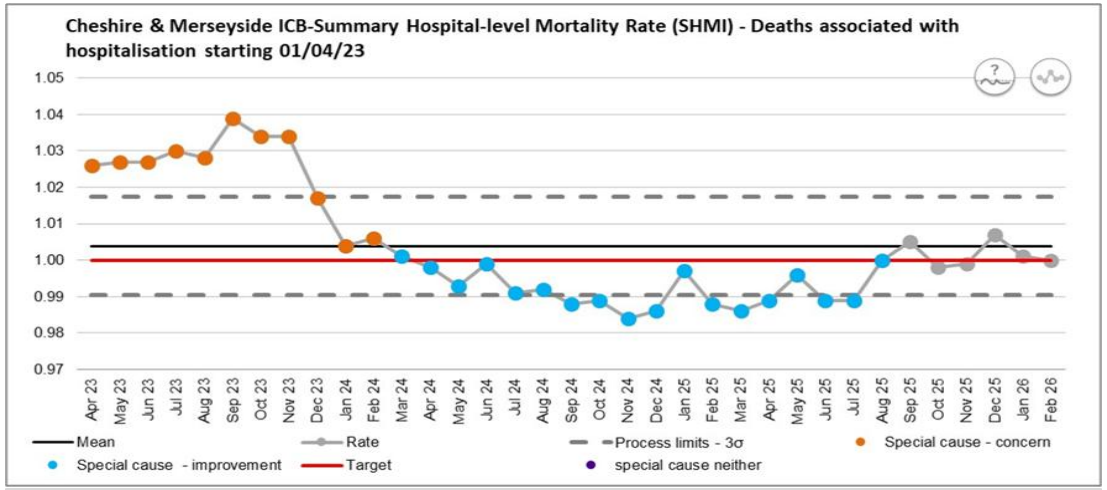
Outcome:

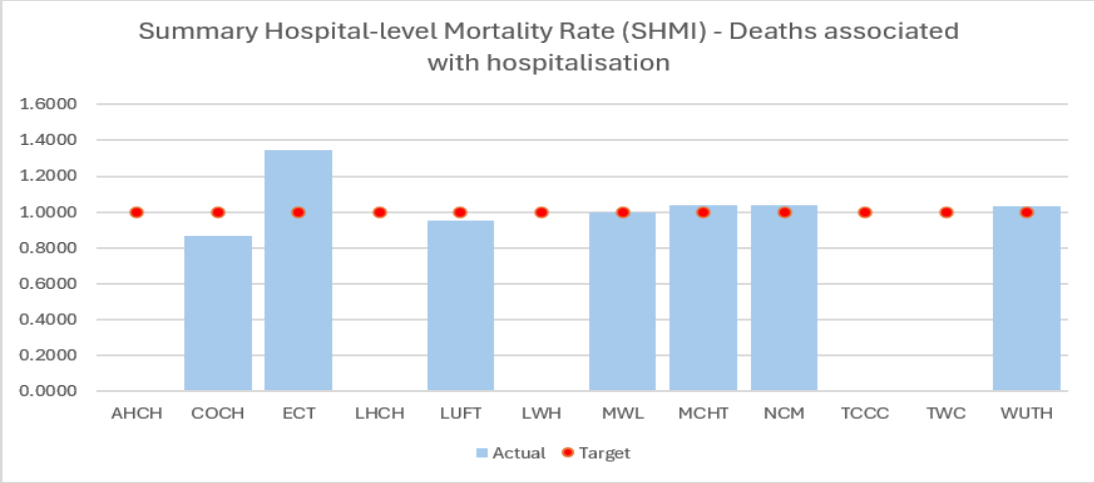
Hospital mortality is in line with or better than expected levels, reflecting safe, high quality care and effective clinical practices

Measure of Progress:

The ration of observed deaths to expected deaths for patients admitted to hospital

Executive Lead: Fiona Lemmens





Summary Hospital-level Mortality Indicator (SHMI)

Issue

- System-wide performance is within the expected range across all organisations **except ECT**.
- ECT reports a **SHMI above the expected range (1.34)**, which continues to increase and is driven by a higher-than-expected rate of deaths within 30 days of discharge, particularly in patients without a palliative diagnosis and following non-elective admissions.

Action (ECT only)

- ECT has moved into a **quality improvement phase** under enhanced governance and escalation processes.
- Ongoing **ICB–provider scrutiny** is in place through board-to-board meetings and system oversight, ensuring appropriate support and challenge to improve outcomes.

Delivery

- A higher proportion of deaths are occurring **outside hospital than expected**, requiring further investigation.
- The Trust is undertaking a **detailed audit of these cases** to understand drivers and identify learning to support improvement.

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Organisational Health (Finance & Workforce)

a) ICB Financial Position
b) CRES v Plan

Organisational Health

Finance - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
Variance between ICB Financial Position v Plan £000 (YTD) (NEW)	Jun-26	£ -	£ -				n/a	n/a	n/a
Variance between Capital Spend v Plan £000 (YTD) (NEW)	Jun-26	£ -	£ -				n/a	n/a	n/a
Variance between CRES v Plan £000 (YTD) (NEW)	Jun-26	-£ 575	£ -				n/a	n/a	n/a

Workforce - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
Workforce - sickness absence rate	Mar-26	4.5%	5.8%				4%	5%	n/a

ICB Financial Position

NHS Cheshire and Merseyside

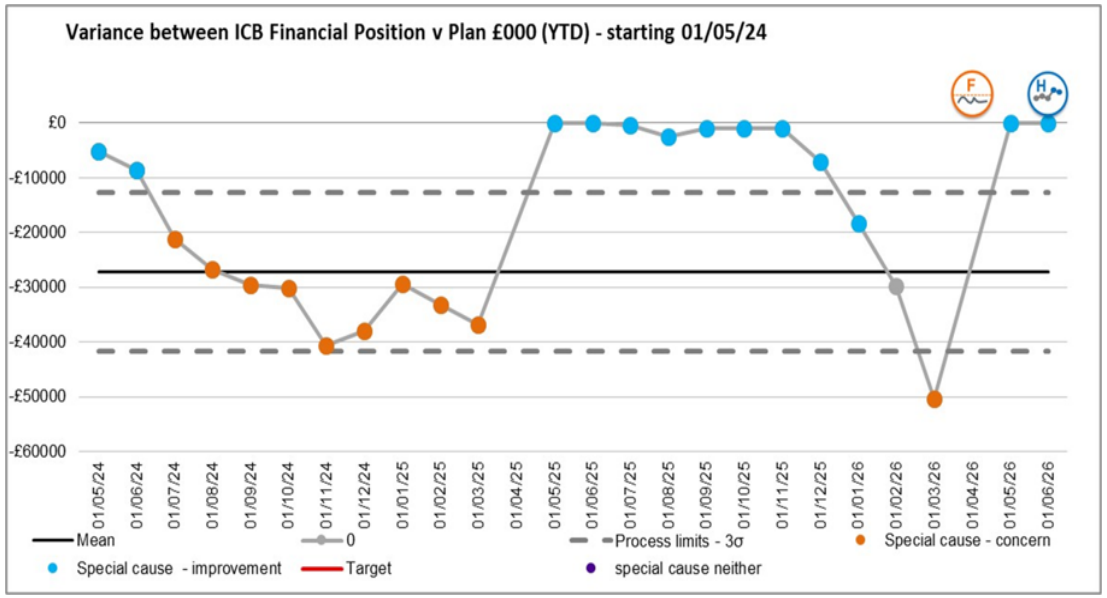
Outcome:

The ICB delivers its planned financial position, demonstrating effective financial management and maintaining system sustainability

Measure of Progress:

This is a financial performance metric that compares the ICB's actual financial position against its planned position.

Executive Lead: Andrea McGee



Variance between ICB Financial Position v Plan

Issue

- The ICB has a **planned breakeven position for 2026/27**, with expenditure of £8.52bn matched to the £8.52bn allocation. Achievement of this position is dependent on delivery of £144m of CRES savings.
- The ICB is reporting a **breakeven year-to-date position at Month 3 (June 2026)** and continues to forecast a breakeven outturn.
- However, early financial pressures are emerging in reablement (£1.2m), ADHD (£0.9m), mental health packages of care (£2.7m), prescribing (£1.3m), and CRES delivery. These pressures are currently offset by underspends in acute activity (£3.0m), CHC (£3.3m), and delegated primary care budgets (£16.0m).

Action

- Financial performance is subject to regular scrutiny through the **Finance, Investment and Commercial Committee (FICC)**, Board reporting, and NHS England oversight arrangements.
- Detailed reporting to FICC includes financial risks, delivery challenges, mitigations, and recovery actions, with a particular focus on CRES delivery and emerging cost pressures.

Delivery

- Overspending areas will continue to be closely monitored and **reported through established governance routes**.
- Mitigating actions will be reviewed and agreed through the **Board and FICC**, with a focus on maintaining delivery of the planned breakeven position and managing emerging financial risks.
- While the reported position remains balanced, delivery of the £144m CRES programme remains a key dependency and financial risk for 2026/27.

CRES vs Plan

NHS
Cheshire and Merseyside

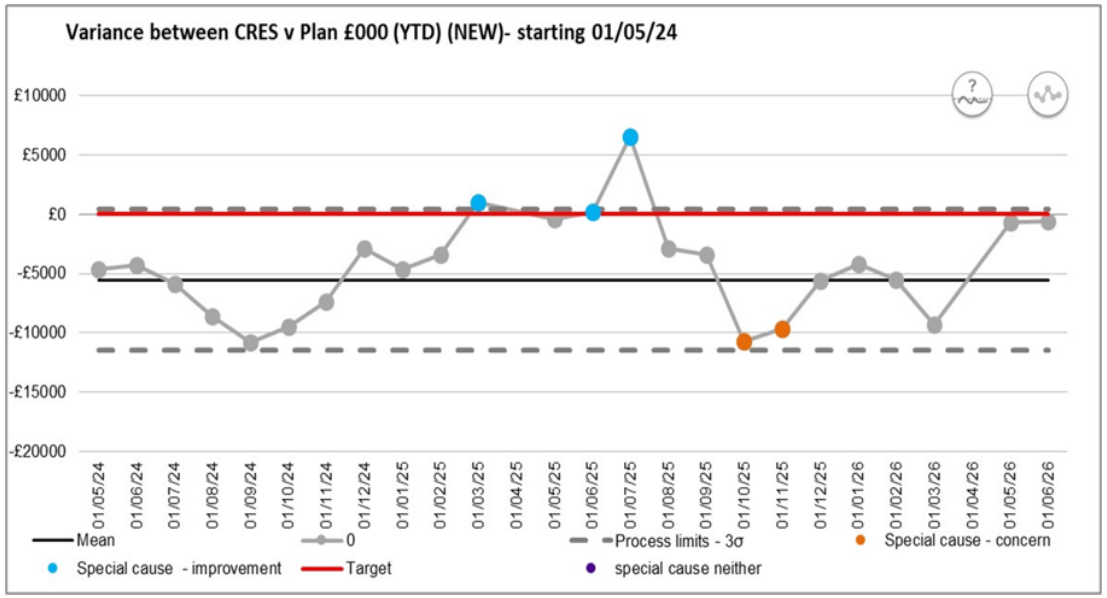
Outcome:

The organisation delivers its planned efficiency savings in full, contributing to financial sustainability while maintaining safe and effective patient care.

Measure of Progress:

The difference between the value of CRES savings planned and the value of CRES savings delivered.

Executive Lead: Jude Adams



Variance between CRES v Plan

Issue

- The 2026/27 CRES target was initially set at **£144m** and has subsequently been increased by **£11.4m to £155.4m**.
- At Month 3, year-to-date CRES delivery is **£25.5m against a planned £26.1m**, resulting in a **£0.6m shortfall** at M3.
- While the current forecast is **£11.4m above plan**, risk adjustment based on delivery confidence reduces this position to **£12.2m below plan**, highlighting a potential delivery risk.
- The current profile assumes 37% of savings will be delivered in the first half of the year and 63% in the second half, **increasing reliance on later-year delivery**.

Action

- CRES performance is reported **monthly to the Finance, Investment and Commercial Committee (FICC), ICB Board, and NHS England**.
- Reporting includes delivery performance, forecast risk, scheme status, and actions required to strengthen delivery against plan.

Delivery

- Work continues to **progress schemes through the pipeline into implementation** to improve delivery confidence and close the current gap to plan.
- Ongoing focus is being placed on **accelerating scheme mobilisation and mitigating forecast risks**, particularly given the significant proportion of savings planned for the second half of the year.
- Achievement of the full £155.4m CRES target remains a key dependency for delivery of the ICB's financial plan.

Integrated Performance Report

Appendix

a) 13-month trend
b) Provider Capability & Segmentation Ratings
c) Guidance
d) SPC Guidance

ICB Aggregate Position - 13 month trend

NHS Cheshire and Merseyside

Metric	Latest Month	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Target	Regional	National	Ranking
Still birth per 1,000 (rolling 12 months)	May-26	2.49	2.44	2.54	2.56	2.60	2.65	2.69	2.51	2.39	2.70	2.70	2.70		2.6	n/a	3.8	n/a
Pre Term Births (NEW)	Apr-26	148	159	126	161	145	122	135	140	110	127	130			TBC	n/a	n/a	n/a
Breast Milk at First Feed % (NEW)	Apr-26	65.3%	64.6%	63.4%	65.2%	67.6%	67.2%	66.3%	64.1%	66.4%	68.4%	67.6%			TBC	n/a	n/a	n/a
Number of 52+ week RTT waits, of which children under 18 years.	May-26	1,031	1,098	1,114	899	992	947	847	731	767	501	478	451		0	n/a	n/a	n/a
Number of unique patients seen by an NHS Dentist – Children (12 month)	May-26	334,907	335,719	336,440	337,729	338,502	338,564	340,663	340,812	341,643	343,051	343,377	343,143		337,612	1,054,212	7,365,400	n/a
The % of people waiting less than 18 weeks on the waiting list (RTT)	May-26	59.0%	58.7%	58.4%	59.2%	59.4%	59.1%	58.7%	58.8%	60.7%	64.5%	64.7%	65.2%		63.7%	64.7%	65.6%	20/36
The % of people waiting more than 52 weeks on the waiting list (RTT)	May-26	3.9%	3.9%	3.9%	3.6%	3.3%	2.9%	2.4%	2.2%	1.9%	1.1%	1.1%	1.2%		1.4%	1.4%	1.4%	19/36
Patients waiting more than 6 weeks for a diagnostic test	May-26	11.4%	11.2%	14.2%	12.4%	9.5%	9.2%	10.2%	10.7%	7.1%	9.8%	13.0%	12.4%		10.4%	13.9%	24.0%	5/36
Number of unique patients seen by an NHS Dentist – Adults (24 month)	May-26	941,865	944,188	944,511	946,089	947,758	947,371	950,458	951,752	952,810	955,218	955,922	954,715		963,452	2,687,769	18,399,528	n/a
% of urgent GP appointments seen within 24 hours (NEW)	May-26											77.6%	79.0%		76.7%	n/a	n/a	n/a
Percentage of ICB inappropriate out of area placement bed days in Adult acute beds	Apr-26	3.0%	2.0%	2.0%	3.0%	3.0%	2.0%	3.0%	3.0%	2.0%	2.0%	1.9%	2.0%		0	1.6%	2.1%	28/42
2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	May-26	73.8%	75.4%	76.2%	72.7%	72.3%	74.2%	74.6%	71.1%	73.5%	79.9%	76.9%	74.4%		75.7%	n/a	69.6%	n/a
Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	May-26	73.6%	71.7%	70.5%	70.6%	73.6%	74.8%	75.3%	71.6%	80.7%	81.2%	77.2%	78.9%		80.9%	n/a	79.0%	n/a
Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems. (Aged 15+)	Jun-26	14.0%	14.0%	14.0%	13.9%	13.8%	16.4%	16.3%	16.3%	16.2%	16.1%	16.1%	16.0%	15.9%	12.0%		12.7%	n/a

ICB Aggregate Position - 13 month trend

NHS Cheshire and Merseyside

Metric	Latest Month	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Target	Regional	National	Ranking
Cervical Screening Rate (NEW)	May-26	68.7%	68.7%	68.5%	68.3%	68.4%	68.3%	68.2%	68.3%	68.3%	68.5%	68.5%	68.3%		80.0%			n/a
Bowel Screening Rate (NEW)	May-26	69.8%	69.9%	69.8%	69.7%	69.7%	69.8%	69.6%	69.5%	69.6%	69.6%	69.4%	69.4%		62.0%			n/a
Breast Screening Rate (NEW)	May-26	71.3%	71.3%	71.3%	71.3%	71.5%	71.4%	71.4%	71.3%	71.0%	70.3%	69.5%	69.3%		70.0%			n/a
MMR Uptake (2 doses by fifth birthday) (NEW)	Q4 25/26			83.6%			85.0%			83.1%					95%	84.6%	84.1%	34/42
4-hour A&E waiting time (% waiting less than 4 hours)	Jun-26	73.0%	71.9%	72.8%	72.5%	71.9%	72.4%	71.5%	71.5%	71.6%	73.8%	74.7%	73.8%	73.2%	78.2%	72.9%	75.0%	24/36
A&E 12 hour waits from arrival (Type 1 & 2)	Jun-26	16.8%	17.0%	16.3%	17.6%	17.2%	17.1%	17.4%	18.7%	18.3%	16.3%	13.1%	17.1%	17.3%	15.6%	13.1%	9.7%	34/36
Percentage of beds occupied by patients no longer meeting the criteria to reside (Rolling 7-day average last week of month)	Jun-26	20.3%	20.0%	20.7%	19.7%	19.1%	19.7%	18.7%	20.4%	21.4%	20.2%	19.9%	19.2%	20.2%	TBC	n/a	n/a	n/a
Percentage of people who are discharged from acute hospital to their usual place of residence (NEW)	Feb-26	83.9%	83.4%	84.1%	82.8%	83.6%	82.0%	82.2%	80.9%	82.2%							81.0%	n/a
Reduction in emergency admissions for people aged 65+ (NEW)	May-26	11,162	11,731	11,358	11,467	11,937	10,987	11,707	11,783	10,385	11,893	11,578	11,608		11,922	n/a	n/a	n/a
Reduction in non-elective admissions for patients with frailty (10% reduction against baseline) (NEW)	May-26	5,373	5,437	5,384	5,428	5,696	5,149	5,270	5,527	4,827	5,517	5,458	5,284		4873.5			
Reduction in the proportion of our population dying in hospital - All ages (NEW)	May-26	45.3%	46.8%	47.6%	47.9%	46.1%	48.3%	46.9%	49.0%	46.8%	47.0%	49.3%	47.0%		49.1%	n/a	42.80%	n/a
Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation	Feb-26	0.989	0.989	1.000	1.005	0.998	0.999	1.007	1.001	1.000					0.887 to 1.127		1.000	n/a
Variance between ICB Financial Position v Plan £000 (YTD) (NEW)	Jun-26	(5)	(307)	(2,430)	(1,033)	(979)	(962)	(7,129)	(18,231)	(29,749)	(50,334)	n/a	£ -	£ -	£0			n/a
Variance between Capital Spend v Plan £000 (YTD) (NEW)	Jun-26	£ 700	£ 700	£ 700	£ 700	£ 700	£ 700	£ 700	£ 700	£ -	£ 24,012	n/a	£ -	£ -	£0			n/a
Variance between CRES v Plan £000 (YTD) (NEW)	Jun-26	£ 165	£ 6,530	(2,863)	(3,432)	(10,674)	(9,636)	(5,583)	(4,236)	(5,511)	(9,327)	n/a	(693)	(575)	£0			n/a
Workforce - sickness absence rate	Mar-26	6.1%	6.1%	6.2%	6.2%	6.2%	6.3%	6.3%	6.2%	5.3%	4.5%				5.8%	4.4%	5.1%	n/a

Oversight Framework - Capability, Segmentations and Ratings

NHS Cheshire and Merseyside

C&M Acute and Specialist Trusts

	Capability Rating	Published Ratings				Published Rankings			
Trust		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4***
Liverpool Heart and Chest Hospital NHS Foundation Trust	Green	1	1	1	1	4/134	3/134	5/134	**4/134**
The Clatterbridge Cancer Centre NHS Foundation Trust	Green	1	1	1	1	8/134	9/134	7/134	**10/134**
The Walton Centre NHS Foundation Trust	Green	1	1	1	1	7/134	5/134	13/134	**14/134**
Alder Hey Children's Hospital NHS Foundation Trust	Green	1	1	1	1	16/134	10/134	14/134	**15/134**
Mersey and West Lancashire Teaching Hospitals Trust	Amber/Green	3	3	3	3	56/134	51/134	83/134	**56/134**
Liverpool Women's NHS Foundation Trust	Amber/Red	3	4	3	3	68/134	109/134	93/134	**72/134**
Mid Cheshire Hospitals NHS Foundation Trust	Amber/Red	3	4	4	**3**	96/134	115/134	118/134	**94/134**
Countess of Chester NHS Foundation Trust	Amber/Red	4	4	4	**3**	133/134	132/134	122/134	**98/134**
Warrington and Halton Teaching Hospitals NHS Foundation Trust	Amber/Red	4	4	4	4	118/134	125/134	106/134	**102/134**
Liverpool University Hospitals NHS Foundation Trust	Red	4	4	4	4	116/134	111/134	113/134	**109/134**
Wirral University Teaching Hospitals NHS Foundation Trust	Amber/Red	4	4	4	4	107/134	110/134	124/134	**123/134**
East Cheshire NHS Trust	Amber/Green	3	4	4	4	99/134	119/134	122/134	**126/134**

Note: Green text indicates an improvement in rating/ranking between Q3 and Q4, Red text indicates a deterioration
***Trusts are ordered by their Q4 ranking**

Oversight Framework - Capability, Segmentations and Ratings

NHS Cheshire and Merseyside

C&M Non Acute Trusts

	Capability Rating	Published Ratings				Published Rankings			
Trust		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4***
Wirral Community Health and Care NHS Foundation Trust	Green	1	1	1	1	12/61	9/61	9/61	**10/61**
Merseycare NHS Foundation Trust	Amber/Green	2	2	2	2	25/61	22/61	23/61	**24/61**
Cheshire and Wirral Partnership NHS Foundation Trust	Amber/Green	4	3	3	3	49/61	44/61	47/61	**45/61**
Bridgewater Community Healthcare NHS Foundation Trust	Amber/Green	3	3	3	**4**	39/61	30/61	37/61	**61/61**

Ambulance Trust - for info only

	Published Ratings				Published Rankings			
Trust	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
North West Ambulance Service NHS Trust		1	1	1		1/10	1/10	3/10

Note: Green text indicates an improvement in rating/ranking between Q3 and Q4, Red text indicates a deterioration
***Trusts are ordered by their Q4 ranking**

Integrated Quality & Performance Report – Guidance:

NHS Cheshire and Merseyside

Provider Acronyms:

CHESHIRE & MERSEYSIDE TRUSTS

AHCH	ALDER HEY CHILDREN'S HOSPITAL NHS FT
COCH	COUNTESS OF CHESTER HOSPITAL NHS FT
CWP	CHESHIRE AND WIRRAL PARTNERSHIP NHS FT
ECT	EAST CHESHIRE NHS TRUST
LHCH	LIVERPOOL HEART AND CHEST HOSPITAL NHS FT
LUFT	LIVERPOOL UNIVERSITY HOSPITALS NHS FT
LWH	LIVERPOOL WOMEN'S NHS FT
MWL	MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST
MCFT	MERSEY CARE NHS FT
MCHT	MID CHESHIRE HOSPITALS NHS FT
NCM	NORTH CHESHIRE AND MERSEY NHS FT
TCCC	THE CLATTERBRIDGE CANCER CENTRE NHS FT
TWC	THE WALTON CENTRE NHS FT
WCHC	WIRRAL COMMUNITY HEALTH AND CARE NHS FT
WUTH	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT

KEY SYSTEM PARTNERS

NWAS	NORTH WEST AMBULANCE SERVICE NHS TRUST
CMCA	CHESHIRE AND MERSEYSIDE CANCER ALLIANCE
CMPC	CHESHIRE AND MERSEYSIDE PROVIDER COLLABORATIVE

OTHER

OOA	OUT OF AREA AND OTHER PROVIDERS

Key:

Data formatting

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

C&M National Ranking against the 42 ICBs

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

C&M National Ranking against the 22 Cancer Alliances

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

Notes on interpreting the data

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

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

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

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

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

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

Integrated Quality & Performance Report – Interpreting SPC Charts:

NHS
Cheshire and Merseyside

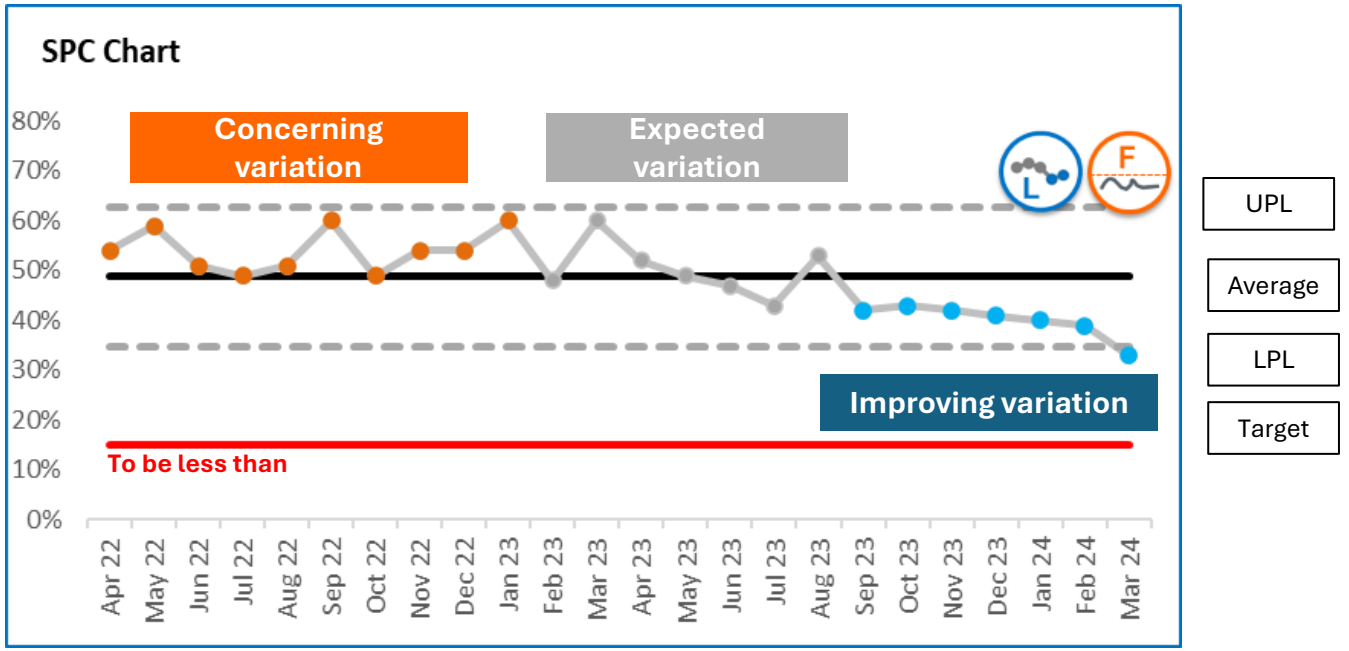
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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

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

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

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



UPL

Average

LPL

Target

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

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

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

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

Integrated Quality & Performance Report – Interpreting summary icons:

NHS Cheshire and Merseyside

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

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

NHS
Cheshire and Merseyside

Meeting of the Quality & Performance Committee of NHS Cheshire and Merseyside

Date: 30 July 2026

Highlight report of the Chair of the Quality & Performance Committee

Agenda Item No: **ICB/07/30/26/17**

Report completed by: **Tony Foy**
Committee Chair: **Tony Foy**

DRAFT

Highlight report of the Chair of the Quality & Performance Committee June 2026 Meeting

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	11 June 2026

Key escalation and discussion points from the Committee meeting

Alert

East Cheshire Trust

- Concerns remain in relation to quality, safety and sustainability. The System Oversight Group has been reestablished and met on 8th June 2026. Specific concerns include recent CQC report rating 'requires improvement', summary hospital level mortality indicator (SHMI) rating of above expected mortality, poor venous thromboembolism (VTE) risk assessment compliance. The Trust remains a mortality outlier, particularly for deaths within 30 days of discharge - the Place Quality team has designed a focused clinical audit due to be completed by the end of June 2026.

Maternity

- East Cheshire remains under enhanced surveillance, with concerns relating to consultant cover, data quality, and the sustainability of the service. The Committee heard that the consultant model was under regional and national oversight. Midwifery turnover rates remain above the England average, largely driven by retirement and work–life balance factors, with an upcoming consultant retirement placing pressure on workforce capacity. Regional assessment noted proactive workforce planning with leadership structures, team midwifery model, and recruitment activity developing, though consultant rota sustainability remains a concern. Members noted that, despite extensive support, progress remained limited, and the position continued to present a significant level of risk.

- North Cheshire and Merseyside (previously Warrington & Halton Trust) has not demonstrated the expected level of improvement and has now been placed under Regional enhanced surveillance. Further work is needed to strengthen governance arrangements, clarify accountability, and evidence effective ward-to-board oversight.

Advise

The Committee advises the Board of the following matters:

Maternity

- **Oversight and Support Framework**
  Countess of Chester Hospital is expected to exit enhanced surveillance following a final visit scheduled for 24 June 2026. The Trust has demonstrated sustained improvement, and the regional team is supportive of the proposed exit. Regional assessment highlighted the new maternity unit as exceptional, and a strong safety culture demonstrated through safety champion ward walks and embedding learning from incidents.

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Mersey and West Lancashire (Ormskirk) has shown substantial improvement and was likely to exit enhanced surveillance in July 2026. Mid Cheshire was awaiting the outcome of a recent CQC inspection, and it is anticipated that the trust would also be able to exit enhanced surveillance if no significant issues were identified.

Mid Cheshire NHS Foundation Trust has demonstrated strong and sustained improvement, with notable progress in leadership engagement, workforce stability, and system collaboration. While this milestone would trigger exit consideration, this has been deferred pending the outcome of the January 2027 CQC inspection and delivery of any subsequent actions

- **Induction of Labour** the Committee heard that the number of inductions had increased significantly due to the implementation of national safety initiatives, including the Saving Babies' Lives Care Bundle. Compliance with the Saving Babies' Lives Care Bundle remained strong across the system, with all providers achieving over 90 per cent compliance and Mersey and West Lancashire and Wirral achieving 100%. This had created pressure on estates and patient flow. As the national sitrep does not provide sufficient granularity to understand the full extent of delays, a deeper dive was underway to identify the root causes and potential mitigations. The Committee has requested that the findings be brought back once the analysis is complete.

- **Strategy** Regional site visits highlight strong culture, engagement, and innovation, alongside key improvement themes including workforce sustainability, governance, data quality, triage standardisation, equity, digital development, and the need to demonstrate measurable, sustained impact. The refreshed Women's Health Strategy sets a whole-life course approach for ICBs, focusing on reducing inequalities, expanding women's health hubs, improving access and pathways, strengthening prevention, and enhancing digital and workforce capability.

All Age Continuing Care

- The Committee received an update on the All-Age Continuing Care service, including an overview of current performance, workforce challenges, contract arrangements and the development of the draft single improvement plan. The service continues to experience significant operational pressure, driven primarily by longstanding workforce shortages and continued reliance on external providers (Wirral) and agency workers.

- The 28-day assessment target for Q4 25/26 was only achieved by St Helens, Knowsley and South Sefton; Cheshire and Wirral both below 50%. There was an overall deterioration for the ICB since Q3 from 63.9% to 57.9%. The ICB remained the only system in the region that had not achieved the 28-day assessment target, and this continues to be a key area of concern for NHSE.

- None of the ICB places reported long waiters in this quarter and all of our places achieved the Location of Assessment standard (assessments not taking place in acute settings).

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Assure

The Committee provides the following assurances to the Board:

Patient Safety Report

- **Training -** Level 1 Patient Safety Syllabus training exceeded the 90% target, while Level 2 training remained slightly below target at 86% - the target was expected to be achieved within the current year. EDI training remained above tolerance at 92.4%.

- **Patient Safety Incident Response Framework (PSIRF) -** Updated PSIRF Plans had now been endorsed for the Countess of Chester and the Walton Centre, and the Committee heard that future reports would highlight any organisations whose plans had not been refreshed within the last 12 to 18 months. No escalations had been raised during the quarter regarding compliance with PSIRF standards.

- **Never Events -** The position remains a concern with ten Never Events reported in Q4 and nine of these relating to invasive procedures. The Committee noted that Never Events continued to highlight gaps in assurance, with some providers submitting evidence focused primarily on theatre settings rather than invasive procedures undertaken elsewhere. No provider was yet fully compliant across all settings. Some trusts had submitted clear improvement plans, while others had not yet provided sufficient assurance. The Committee expressed concern regarding the pace of progress and requested strengthened oversight through contract meetings.

Performance

- Performance in **urgent and emergency care** had seen slight improvement, with the system achieving the national standard for Category 2 ambulance response times in April. Four-hour performance has also strengthened, reflecting improvements in flow and operational management. However, 12-hour waits remained a significant challenge, with the system continuing to be an outlier nationally. High bed occupancy and limited discharge capacity were identified as the primary drivers of this position. Members acknowledged the improvement trajectory but emphasised the need for continued focus on reducing long waits.

- **Elective recovery** performance had improved markedly at year-end. The system had exceeded the 25/26 RTT 18-week target, a significant achievement given the operational pressures experienced throughout the year. **Diagnostics performance** remained strong, with the system continuing to perform above national averages.

- The Committee discussed the importance of ensuring that the dashboard continued to evolve to reflect system priorities, including the need for improved visibility of community and primary care performance. Members also emphasised the importance of triangulating performance data with quality and patient experience intelligence to provide a more comprehensive picture of system pressures

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Committee risk management

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

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
P4 potential for major quality failures	Maternity performance reviewed and challenges clarified

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Urgent and Emergency Care	Elective and UEC improvement – 12 hour waits require further analysis and action
Maternity	Review of enhanced surveillance Trusts

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NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

30th July 2026

Highlight report of the Chair of the ICB Audit Committee

Agenda Item No: **ICB/07/30/26/18**

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Audit Committee

Committee Chair	Mike Burrows
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	9th June 2026

This report summarises the Audit Committee's key alerts, advice and assurances from its June 2026 meeting, during a period of organisational transition.

Key escalation and discussion points from the Committee meeting

Alert

- **Annual Report and Accounts 2025/26**: The Committee reviewed the draft Annual Report and Accounts and noted amendments made following the May 2026 extraordinary meeting. Members raised points on corridor care data and Board visibility of specialised commissioning, with assurance provided that these areas are being addressed through OPIC and executive review. No further concerns were identified, and the Committee approved the report for onward Board approval on 18th June 2026.

- **External Audit Annual Report 2025-26:** The Committee noted that the external audit is substantially complete and on track, with auditors expecting to issue an unqualified audit opinion and clean regulatory opinion. Key audit testing identified no significant concerns, with only minor disclosure amendments and immaterial misstatements reported. The Committee noted recommendations on provider contracts and Section 75 agreements, received assurance on improved contract sign-off, thanked colleagues for their work, and recommended the audit findings report to the Board.

- **External Audit Findings Report/Letter of Representation:** The Committee considered the report, which identified significant weaknesses in financial sustainability and governance. Members acknowledged the system's financial position and NHSE enforcement undertakings, while noting progress in financial management, forecasting, governance and organisational effectiveness. The Committee received assurance that the recommendations align with existing improvement work and approved the report's recommendation to the Board.

Advise

- **Head of Internal Audit Opinion 2025/26:** The Committee noted the final Head of Internal Audit Opinion, with no material changes from the previous draft. The opinion provided overall **moderate assurance** on governance, risk management and internal control for 2025/26.

- **Freedom of Information Q4 2025/26 Update Report:** The Committee noted that FOI activity remained high, averaging 47 requests per month, while compliance with response requirements remained strong.

Assure

- **Freedom to Speak Up (FTSU) Update:** The Committee received assurance on progress in strengthening FTSU arrangements, including alignment with national guidance and enhanced NED oversight. Members noted high staff awareness at 90%, reduced confidence linked to organisational change, low senior leadership training uptake and a high number of anonymous reports. The Committee noted planned work to improve Guardian visibility and embed a strong speak-up culture.

- **Declarations of Interest Q4 2025-26 Update Report:** The Committee received assurance that arrangements for managing declarations remain robust, with compliance at 92% against a 95% target. Members noted the need to improve senior leadership compliance and embed training following organisational change. Gifts and hospitality declarations were reviewed and managed appropriately.

- **Anti-Fraud 2025/26 Work Annual Report:** The Committee received assurance on the effectiveness of the ICB's Anti-Fraud, Bribery and Corruption programme. Delivery against the NHS Counter Fraud Authority strategy was achieved, with eleven green ratings and one amber rating in the annual assessment. Members noted fraud prevention activity, the National Fraud Initiative, successful referral management, and planned review of controls for personal health budgets through internal audit.

The next meeting of the Committee is scheduled for **1st September 2026.**

Appendices

None

Meeting of the System Primary Care Committee of NHS Cheshire and Merseyside

30 July 2026

Highlight report

Agenda Item No: **ICB/07/30/26/19**

Highlight report of the Chair of the SPCC Committee

Committee Chair	*Erica Morriss*
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	*June 26*

Key escalation and discussion points from the Committee meeting

Alert

The System Primary Care Committee met to review financial assurance, operational progress, and emerging risks across primary care workstreams. The Committee noted early-stage variances in primary care and dental budgets, reviewed local service stability measures, and evaluated ongoing structural adjustments.

GP Practices Operating out of Lease

- **Risk Profile**: A number of GP practices continue to operate from premises without valid lease agreements, posing financial and operational risks to the ICB (including potential landlord Section 25 vacate notices). Technically, formal leases are legally required under premises directives to issue rent payments.
- **Key Concerns**: High risks are noted in third-party or privately owned properties due to potential sudden landlord actions. While members expressed concern that the proposed 26-week timeline to secure leases is ambitious given multi-year backlogs, the committee agreed clear timeframes are necessary to break the impasse.
- **Practical Hurdles**: Main challenges include difficult landlord engagement, long-standing disputes, and the knock-on risks to co-located services like pharmacies.
- **Proposed Escalation Strategy**: A structured, non-punitive, risk-based approach will focus on highest-risk practices via formal letters. However, the withholding of rent may ultimately be deployed as a final lever to prompt action. The ICB will work closely with Local Medical Committees (LMCs) to support practice engagement.
- **Committee Outcome**:
  - **APPROVED** the introduction of a formal three-stage escalation (breach) process for non-compliant practices.
  - **ENDORSED** the supporting governance framework.
  - **SUPPORTED** continued collaborative work across Estates, Contracts, and Finance to develop a Standard Operating Procedure (SOP).

Advise

Policy and Commissioning

1. Primary Care Action Plan

- **Status Update**: The Primary Care Action Plan has been approved by the Board and submitted to NHSE. Initial regional feedback is positive, pending national moderation.

- **Plan Scope**: This nationally required framework covers all 4 contractor groups. It outlines how the ICB will address unwarranted variation, manage contracts, and deliver priorities like access and Pharmacy First.
- **Delivery & Expectations**: High-level content with more detailed local delivery and commissioning plans in Aug.
- **Assurance Shift**: Future reporting will move away from granular operational details. Instead, it will use a **RAG-rated approach** focused on high-level progress, risks, underperformance, and mitigation.
- **Public Voice**: Healthwatch is gathering real-time public feedback across all 4 contractor groups. They will present a detailed update at a future meeting to ensure performance metrics are balanced against lived patient experiences.

Committee Outcome: The Committee **NOTED** the draft Primary Care Action Plan and the proposed reporting/next steps.

2. Primary Care Commissioning Update

- **Status Update**: The committee reviewed the consolidated update covering delegated commissioning arrangements, performance reporting, and assurance metrics across all 4 contractor groups.
- **Governance Reassurance**: The annual self-assessment of delegated primary care commissioning was completed for the previous year with no significant issues identified, confirming robust governance.

3. Community Pharmacy Contract Update

- **Funding Realities**: The 2026/27 Community Pharmacy Contractual Settlement introduces a 10.3% funding uplift. However, following a prolonged period of flat funding, the sector remains significantly underfunded overall.
- **Investment Focus**: Most new funding is directed toward dispensing activity and core business margins rather than expanding clinical services this year.
- **Sustainability Risks**: Inflation, workforce costs, medicine supply issues, and price concessions continue to threaten long-term pharmacy financial stability and patient access.
- **Prescribing Constraints**: Short-term uptake of the new national prescribing service will be limited by workforce constraints, clinical risks, indemnity requirements, and low funding structures.
- **ICB Strategy**: The contract signals a long-term shift toward a clinical pharmacy role. The ICB emphasised its commitment to supporting the sector through governance setup and planning for gradual service expansion.
- **Vaccinations**: New national updates regarding vaccination programmes (including Meningitis B) were acknowledged, though full implications are still being assessed.

Committee Outcome: The Committee **NOTED** the update regarding the Primary Care Action Plan, Commissioning and nationally agreed contract settlement.

🏢 Estates

1. Business Case Approval of Neighbourhood Bespoke Layer in STRATA

- **Strategic Objectives**: The business case seeks approval to map estate assets against population health needs to strengthen estates intelligence and bolster neighbourhood planning. The development will transition decision-making from

an initial NHS estate focus to subsequently incorporate local authority and voluntary sector assets.

- **Key Discussions**:
  - **System Alignment**: Alignment with adjacent systems (e.g., Greater Manchester) will be explored to guarantee operational consistency and avoid duplication.
  - **Data Scope**: While the initial focus remains on core estates data, the tool retains the capacity to incorporate broader data layers over time
  - **Governance & Maintenance**: Joint responsibility will reside between the estates and business intelligence teams.
  - **Planning Scope**: The committee emphasised using cross-boundary provision to reflect true patient access trends over strict geographic boundaries. The core purpose must complement existing tools without premature expansion of functionality.
- **Funding**: Finances have already been allocated; no additional funding was requested.

Committee Outcome: The Committee **APPROVED** the use of Business-as-Usual Capital Allocation to develop a bespoke Neighbourhood layer in STRATA for Cheshire and Merseyside.

Assure

💰 **Finance**

1. **Finance Update**
   - **Budget Position**: An early-stage surplus was noted within the delegated primary care budget for month 2.
   - **GP reimbursement scheme**: The GP Scheme (launched in April) required significant operational effort to support practices with the CQRS Local system. Early implementation issues are being resolved, and practices are expected to claim funding on time.
   - **Dental Budgets**: An apparent underspend of approximately £9.9 million was reported. However, this funding is fully committed to contractual obligations and will be reinvested into dental services.
   - **Dental Pressures**: Recent contractual changes remain under review and impact will need to be factored into our planning approach.
   - **'Ghost Patients'**: Around 3,500 patients were removed from practice lists following national policy changes, which may disproportionately affect specific practices and patient groups. Further information is being provided by NHS England.
   - **Local Enhanced Services (LES).** Next progress report in August will provide options around timings and full review will take place in October 26 with ongoing consultation with LMC's.

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2. **Prescribing**
   - **Data Constraints**: No up-to-date prescribing data was available for review, limiting the assurance that could be provided at this stage of the financial year.
   - **Future Risks**: While the current position appears stable, future pressures are anticipated from national changes. These include the reintroduction of clawback mechanisms and increased costs from new NICE technology appraisals.

3. Utilisation and Modernisation Fund 25/26 Programme Update

- **Programme Status**: Approximately £5.9 million has been deployed across 50 schemes, with the vast majority either finalised or actively progressing. Additional funding was successfully leveraged from an external ICB to maximise delivery impact.
- **Challenges Overcome**: The program encountered implementation difficulties stemming from evolving national criteria, criteria for eligible schemes, complex legal requirements (such as licenses to occupy), and ongoing landlord negotiations. These issues have been actively managed to keep current schemes moving forward.

Committee Outcome: The System Primary Care Committee **NOTED** the combined financial summary position as of 31st May 2026 and the UMF 25/26 update.

Achievement of the ICB Annual Delivery Plan

The Committee considered the following areas that directly contribute to achieving the objectives against the service programmes and focus areas.

Service Programme / Focus Area	Key actions/discussion undertaken
Estates	Utilisation of budget and best practices
Primary Care Action Plan	ICB's approach to variation, managing contracts and improving access across all 4 contractor groups.
Technology	Ensuring future fit approach to population demand through Strata.

NHS
Cheshire and Merseyside

Meeting of the NW Specialised Services Committee

30 July 2026

Highlight report of the Chair of the NW Specialised Services Committee

Agenda Item: **ICB/07/30/26/20**

Committee Chair: **Steve Spill**

NHS
Cheshire and Merseyside

Highlight report of the Chair of the North West Specialised Services Committee

Committee Chair	Steve Spill
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/media/ev1dushd/2024-25-nw-sp-jc-terms-of-referencev14-final.pdf
Date of meeting	29th April 2026

Key escalation and discussion points from the Committee meeting

Alert

- Significant risk remains regarding the Adult Critical Care Transfer Service (ACCTS) due to the absence of capital funding, preventing procurement of a compliant service and requiring continued reliance on interim arrangements which potentially pose workforce and patient safety risks
- Ongoing operational and quality pressures across specialised services were noted, including cardiac waiting times, cancer performance, neurosciences capacity, renal dialysis incidents and breast screening delays
- The closure of Saint Andrew's Healthcare continues to create system pressure on secure mental health provision and bed capacity nationally

Advise

- Capital funding for ACCTS requires urgent national resolution, with escalation supported through a joint NHS England and ICB submission.
- Further development is needed to strengthen pathway-level financial insight and support strategic commissioning decisions
- Work is required to clarify governance arrangements under OPIC, including roles, accountability and committee structures
- The Committee supports enhanced alignment between specialised commissioning and ICB quality governance and strengthened shared learning approaches

Assure

- A balanced financial plan for 2026/27 has been developed, with most contracts agreed and robust oversight through established governance arrangements.
- Quality concerns are actively managed, with oversight through regional and ICB governance structures and improvements to reporting.
- Transformation programmes, including the ROP service model, are delivering measurable improvements in access, consistency and patient safety.
- Governance arrangements are being reviewed and strengthened in line with OPIC development, including improved structure and reporting approaches.

Regional Director Update	• Noted implementation of revised neurology and haemophilia service specifications from 2026/27. • Highlighted closure of Saint Andrew's Healthcare and associated system pressures on secure mental health capacity. • Received update on OPIC development, with shadow arrangements expected from October. • Noted ongoing workforce implications, including voluntary redundancy timelines. Action: AB to confirm and report back on the feedback received from the national consultation on the revised neurology service specification.
ICB update	• Reported progress on GM specialised cardiac and vascular service proposals, with positive clinical senate feedback. • Noted delays in GM major trauma work due to capacity and workforce constraints. • Highlighted local operational pressures, including cardiac waiting times and breast screening challenges. • Confirmed ongoing system reform and organisational transition aligned to OPIC.
Items for decision/endorsement • ACCTS update	• Noted inability to progress procurement due to lack of capital funding. • Confirmed interim arrangements remain in place, not fully meeting national. specifications but closely monitored by the ODN. • Highlighted workforce and patient safety risks associated with current model. • Agreed to escalate nationally and maintain current position pending resolution.
Quality Update	• Reviewed renal dialysis incidents, including serious patient safety concerns. • Noted breast screening delays and cancellations, with mitigating actions in progress. • Confirmed ongoing investigations, oversight and improvement actions.

	• Welcomed revised quality reporting approach, supporting shared learning and alignment.
Finance & Planning Update	• Noted balanced financial plan for 2025/26 and progress on contract agreement. • Highlighted key risks, including elective demand, cancer pressures and activity variation. • Identified need for improved pathway-level financial insight. • Confirmed ongoing collaboration across NHSE, ICBs and providers. Action: IL to develop and bring back a service level spend analysis, drawing on indicative activity plans, to support improved understanding of where specialist commissioning resources are deployed. Action: SCOGS to identify one or two priority pathways or service areas for initial in depth, cross ICB analysis to inform future strategic commissioning decisions.
Risks	• Reviewed current and emerging risks across specialised services. • Highlighted pressures in neurosciences and provider-specific issues. • Noted full review of risk register underway, including alignment with OPIC.
Mental Health Update	• Noted temporary closure of Anderson Mother and Baby Unit due to significant estates issue. • Confirmed mutual aid arrangements supporting patients safely. • Highlighted reopening of Sunflower House and increased CAMHS capacity. • Reported new inpatient CAMHS provision now operational.
ROP Impact Report	• Noted implementation of regional ROP screening model across all neonatal units. • Reported improvements in screening coverage and timeliness.

	• Highlighted ongoing risks, including workforce gaps, IT interoperability and equipment replacement. • Agreed further work required to ensure long-term sustainability and accountability. **Action:** Clarify how long-term accountability and sustainability for the Retinopathy of Prematurity (ROP) service will be secured, including how this will be incorporated into wider neonatal review and commissioning arrangements. **Action:** Bring back a further update to the committee setting out how ROP service governance, oversight and accountability have been embedded within neonatal review arrangements and future commissioning models.
AOB	• Confirmed July meeting to take place virtually. • Noted future in-person meetings to be reviewed in line with OPIC developments.