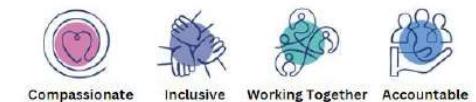


Meeting of the Board of NHS Cheshire and Merseyside

(held in public)

29 January 2026
14:00pm

**Liverpool Suite,
Holiday Inn, Lime Street,
Liverpool, L1 1NQ**



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-january-2026/>

Agenda

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
14:00pm	Preliminary Business				
ICB/01/26/01	Welcome, Apologies and confirmation of quoracy	Verbal	Sir David Henshaw <i>ICB Chair</i>	For information	-
ICB/01/26/02	Declarations of Interest <i>(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published on the ICB website)</i>	Verbal		For assurance	-
ICB/01/26/03	Minutes of the previous meeting: • 27 November 2025.	Paper		For approval	Page 6
ICB/01/26/04	Board Action Log	Paper		For approval	Page 15
ICB/01/26/05	Key issues – significant items to raise	Verbal		For discussion	-
ICB/01/26/06	Chairs announcements	Verbal		For information	
ICB/01/26/07	Questions received from members of the public	Verbal		For information	-
ICB/01/26/08	Experience / achievement story	Film		For information	-
14:25pm	ICB Business Items				
ICB/01/26/09	Women's Hospital Services in Liverpool - Options Appraisal and Next Steps	Paper	Dr Fiona Lemmens <i>Deputy Medical Director</i> James Sumner <i>Joint Chief Executive, LUFHT & LWH</i>	For decision	Page 16
ICB/01/26/10 14:45pm	Lung Cancer Screening: Phase 5 Procurement Recommendations	Paper	Jon Hayes <i>Managing Director</i> C&M Cancer Alliance	For approval	Page 68
15:05pm	Leadership Reports				
ICB/01/26/11	Report of the ICB Chief Executive	Paper	Liz Bishop <i>Chief Executive</i>	For assurance	Page 73
ICB/01/26/12 15:15pm	Cheshire and Merseyside ICB and System Finance Report - Month 9	Paper	Andrea McGee <i>Interim Executive Director of Finance and Contracting</i>	For assurance	Page 90

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
ICB/01/26/13 15:30pm	Highlight report of the Chair of ICB Finance, Investment and Our Resources Committee	Paper	Sue Lorimer <i>Non-Executive Member</i>	For assurance	Page 102
ICB/01/26/14 15:35pm	NHS Cheshire and Merseyside Integrated Performance Report	Paper	Jude Adams <i>Interim Executive Director of Transformation & Strategy (Turnaround)</i>	For assurance	Page 178
ICB/01/26/15 15:45pm	Highlight report of the Chair of ICB Quality and Performance Committee	Paper	Tony Foy <i>Non-Executive Member</i>	For assurance	Page 150
ICB/01/26/16 15:50pm	Highlight report of the Chair of the Audit Committee	Paper	Mike Burrows <i>Non-Executive Member</i>	For approval	Page 156
ICB/01/26/17 15:55pm	Highlight report of the Chair of System Primary Care Committee	Paper	Tony Foy <i>Non-Executive Member</i>	For assurance	Page 174
16:10pm	Closing Business				
ICB/01/26/18	Closing remarks and review/reflections of the meeting	Verbal	Sir David Henshaw <i>ICB Chair</i>	For information	-
ICB/01/26/19	Any Other Business	Verbal		For information	-
16:15pm	CLOSE OF MEETING				

Consent items

All these items have been read by Board members and the minutes of the January 2026 Board meeting will reflect any recommendations and decisions within, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.

AGENDA NO	ITEM	Reason for presenting	Page No
ICB/01/26/20	Board Decision Log (CLICK HERE)	For information	-

Consent items

ICB/01/26/21	Confirmed Minutes of meetings of the ICB Committees: <ul style="list-style-type: none">• Audit Committee• Finance, Investment and Our Resources Committee• Quality and Performance Committee• System Primary Care Committee• Women's Hospital Services in Liverpool Committee	For assurance	Page 178
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Date and start time of future meetings

26 March 2026, 10:00am, Conference Suite, Riverside Innovation Centre, 1 Castle Drive, Chester, CH1 1SL

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

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

**27 November 2025, 1.00pm,
4/Twenty Lounge, The Halliwell Jones Stadium, Warrington Conference Centre
Mike Gregory Way, Warrington. WA2 7NE**

Draft Minutes

ATTENDANCE	
Name	Role
Members	
Sir David Henshaw	Chair, Cheshire & Merseyside ICB (voting member)
Liz Bishop	Chief Executive, Cheshire & Merseyside ICB (voting member)
Andrea McGee	Executive Director of Finance (Interim), Cheshire & Merseyside ICB (voting member)
Christine Douglas, MBE	Executive Director of Nursing and Care, Cheshire & Merseyside ICB (voting member)
Prof. Rowan Pritchard-Jones	Medical Director, Cheshire & Merseyside ICB (voting member)
Tony Foy	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Dr Ruth Hussey, CB, OBE, DL	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)
Janelle Holmes	Partner Member (NHS Trust), Cheshire & Merseyside ICB (voting member)
Adam Irvine	Partner Member (Primary Care), Cheshire & Merseyside ICB, (voting member)
Dr Naomi Rankin	Partner Member (Primary Care) (voting member)
Delyth Curtis	Partner member (Local Authority) (voting member)
Andrew Lewis	Partner Member, (Local Authority) (Voting Member)
In Attendance	
Clare Watson	Assistant Chief Executive, Cheshire & Merseyside ICB (regular participant)
Anthony Middleton	Director of Performance and Planning, Cheshire & Merseyside ICB (regular participant)
Dr Fiona Lemmens	Deputy Medical Director, Cheshire & Merseyside ICB (regular participant)
John Llewellyn	Chief Digital Information Officer, Cheshire & Merseyside ICB (regular participant)
Prof. Paul Kingston	Chair of ICB Research and Innovation Committee, (regular participant)
Louise Barry	Chief Executive (Cheshire Healthwatch), C&M Healthwatch Representative
Prof. Ian Ashworth	Director of Population Health, Cheshire & Merseyside ICB (regular participant)
Mike Gibney	Chief People Officer, Cheshire & Merseyside ICB (regular participant)
Alison Lee	Director of Transformation (Interim), Cheshire & Merseyside ICB (regular participant)
Louise Murtagh	Note taker, Cheshire & Merseyside

Apologies	
Name	Role
Mandy Nagra	Chief System Improvement and Delivery Officer
Prof Hilary Garratt, CBE	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Warren Escalade	Partner Member (VCFSE) (Voting Member)
Erica Morriss	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Ellen Loudon	C&M Health and Care Partnership Vice-Chair (regular participant)

Agenda Item, Discussion, Outcomes and Action Points

Preliminary Business

ICB/11/27/01 Welcome, Apologies and confirmation of quoracy

The Chair welcomed the Board to the Public Board, apologies were noted, and it was confirmed that the Board was quorate.

Sir David introduced himself as the Chair of NHS Cheshire and Merseyside and Liz Bishop as the Chief Executive Officer. Both posts had been appointed to since the last Board meeting.

Following discussions with members of the public prior to the start of the meeting, it was agreed to that Item 21 be moved to the start of the agenda.

ICB/11/27/21 Questions received from members of the public

The Board received 10 questions from the public in advance of the meeting. The Chair confirmed that written answers would be provided to individuals following the meeting. Questions related to:

ICB/11/27/02 Declarations of Interest

There were no declarations of interest made by members that would materially or adversely impact matters requiring discussion and decision within the listed agenda items.

ICB/11/27/03 Minutes of the previous meeting of 25 September 2025

The minute of the previous meeting held of 25 September 2025 were accepted and recorded as a true and accurate reflection of the meeting.

Under matters arising Ruth Hussey referred to ICB/09/25/14, the highlight report of the Chair of the North West Specialised Services Joint Committee. The question related to the validity of the decision made. Claire Watson updated that the joint committee had met in June to discuss lead provider collaborates and procurement. Following this meeting several of the providers had received a tiering categorisation that would have prevented the organisation being awarded lead provider status and therefore nullifying the decisions made by committee.

An extra-ordinary meeting was subsequently held where the original decision was reversed with a one-year extension offered in place whilst the procurement mechanism was being reviewed.

This would secure continuity of service for patients however it was noted that tiering was reviewed quarterly and this made strategic commissioning difficult. This was being considered by both the North West team locally and nationally.

ICB/11/27/04 Board Action Log

The Board agreed the actions as listed.

ICB/11/27/05 Key Issues – significant issues to raise

There were no key issues raised by Board members.

ICB/11/27/06 Experience and achievement story

Chris Douglas introduced a video that highlighted the work of the NHS Merseycare Foundation Trust

Agenda Item, Discussion, Outcomes and Action Points

Building Attachments and Bonding Service (BABS)

(BABS) helped parents who were experiencing difficulties bonding or developing their relationship with their baby. This included but was not limited to families who were open to past or present safeguarding services, parents who struggle with their mental health and wellbeing, families who have issues with drug or alcohol use or domestic abuse, parents with mild to moderate mental health vulnerability or past trauma or abuse or those who may have had other children removed from their care in the past.

Users of BABS provided real life experiences how the service had positively impacted on their lives as parents.

Trish Bennett confirmed that BABS was currently available in Halton, Knowsley, Sefton, St Helens and Warrington and the plan was to extend further across Cheshire and Merseyside. The benefits of BABS were multifaceted. As demonstrated in the video, parents reported mental health improvements and that they had been able to keep their families together. There was also a financial benefit to the system linked to costs associated with removing a child from their family into care.

The Board noted the update.

Leadership Reports

ICB/11/27/07 Chairs Announcements

The Chair advised that he had not announcements to make at this point.

ICB/11/27/08 Report of the ICB Chief Executive

Liz Bishop began with a thank you to all staff across NHS organisations who had supported during the latest industrial action by resident doctors.

All other updates were as listed in the report.

Chris Douglas referred to the Adult Social Care (ASC) Nurse Prescribing Pilot as detailed in the report and confirmed that the ICB was one of six ICBs nationally selected, that 18 nurses had been recruited and were due to start their courses. Evaluation was central to the pilot and the benefits, such as how the additional roles would support the system would be monitored.

The Board noted the update.

ICB/11/27/09 Cheshire and Merseyside ICS Finance Month 7 Report Summary Update

Andrea McGee, presented the Month 7 financial position as at 31 October 2025. She reported a year-to-date (YTD) deficit of £138m against a planned YTD deficit of £78.6m, resulting in an adverse variance of £59.4m, entirely attributable to withheld Deficit Support Funding (DSF). Excluding the DSF, the ICS is reporting on plan at Month 7, having mitigated the unplanned costs of industrial action.

Andrea advised that the first seven months of the financial year had consumed 102% of the annual deficit plan, highlighting the need for a material improvement in the financial run-rate for the ICS to meet its year-end position. She confirmed that Region is withholding DSF until the ICS can evidence a clear and credible plan demonstrating how the run-rate will be improved.

The Board was advised that the current mid-case forecast stands at a £349m deficit, which is £171m off plan, with a best-case forecast of £243m (£65m adverse to plan). The forecast trajectory presented was too slow to provide assurance of achieving the planned deficit. Andrea noted that NHS England is working alongside system partners to develop a consistent view of the underlying financial position across the ICS.

She also drew attention to a £112m reduction in cash at Month 7 compared to Month 12 of 2024/25, reiterating that improving the run-rate is essential not only for achieving the financial plan but also for

Agenda Item, Discussion, Outcomes and Action Points

protecting cash balances, given that the ICS has already requested £82.6m of distressed cash support this year.

The Board noted the report.

ICB/11/27/10 Highlight report of the Chair of ICB Finance, Investment and Our Resources Committee

The Board received summary updates from the Chairs of the Finance, Investment and Our Resources Committee covering both meetings held since the last Board meeting.

Mike Burrows reported on the 21 October 2025 committee meeting. He advised that members had reviewed the deteriorating financial position and had concluded that the scale of financial risk had become fully crystallised at that point. The committee agreed that the existing financial plans and cost improvement programme were not sufficient to bridge the gap, leading to the commencement of more robust financial recovery work. The committee also endorsed the financial governance review plan, recognising the need to strengthen oversight and ensure clearer accountability across system partners.

Sue Lorimer updated the Board on the 27 November 2025 committee meeting. She confirmed that members continued to develop and refine the recovery plan, noting that NHS England had signalled the need for more detailed tracking of cost improvement plans and more robust testing of remediation strategies. To support this, PwC had been invited to the next committee meeting to assist with the complex work required with provider organisations as part of financial recovery planning. The committee also held discussions on long-standing contract anomalies, recognising these as a contributory factor to financial instability across the system.

The Board noted the reports

ICB/11/27/11 NHS Cheshire and Merseyside Integrated Performance Report

Anthony Middleton presented the Integrated Performance Report for November, providing an overview of key metrics drawn from the 2025/26 operational plans. The report covered performance across Urgent Care, Planned and Elective Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance.

The Board received further analysis in areas where performance was not currently meeting plan, with particular focus on urgent and emergency care pressures, ambulance response and handover times, planned and elective care activity, and cancer performance trajectories.

The Board noted the sustained improvements in ambulance response times and handover delays, which had reduced markedly compared to the same period in the previous year, though this continued to correlate with challenges in four-hour and twelve-hour emergency department waits.

In planned care, the Board discussed the continued progress in reducing the number of long waiters, including patients waiting over 65 weeks, despite the impact of recent industrial action. Providers had maintained over 90% of planned elective activity during this period, and the system remained focused on meeting national expectations to eliminate the longest waits through provider collaboration, mutual aid, and improved theatre efficiency.

Performance in cancer services was reported as broadly strong at system level, though a small number of pathways were sitting slightly below trajectory. Assurance was provided that actions already underway were expected to restore performance during Quarter 1.

During the discussion, Alison Lee referred to the emerging 12 national indicators for Integrated Neighbourhood Teams, noting that these would become a key component of national performance expectations. She advised that these indicators would need to be incorporated into future iterations of the

Agenda Item, Discussion, Outcomes and Action Points

performance report to support clearer Board-level oversight of neighbourhood-level impact and outcomes. Further work would be required to ensure that the data is presented in a way that is meaningful to the Board and aligned with developing national guidance.

The Board noted the report.

ICB/11/27/12 Highlight report of the Chair of ICB Quality and Performance Committee

Tony Foy provided a verbal summary of the ICB Quality and Performance Committee report.

Highlights from these included risks associated with neurodevelopment delays and referred specifically to ADHD and ASD assessments. Mitigation against these risks included a planned regional summit to address pathways and implement a 90-day collaborative improvement programme. The Neurodiversity Pathway profiling tool was being implemented across all C&M schools. A new 'needs led' model in Primary Care was also being rolled out.

The committee had also discussed key safeguarding concerns and workforce challenges as detailed in the report.

Tony Foy, Chair of the Quality & Performance Committee, provided a verbal overview of the Committee's highlight report. He drew attention to the significant risks associated with neurodevelopmental delays, with particular reference to ADHD and ASD assessment backlogs.

The Board was informed of the mitigations underway, including plans for a regional summit to address pathway issues and the introduction of a 90-day collaborative improvement programme to accelerate progress. Tony also highlighted that the Neurodiversity Pathway Profiling Tool was being implemented across all Cheshire & Merseyside schools to support earlier identification and more consistent support for children and young people. A new 'needs-led' model in Primary Care was also being rolled out to strengthen early intervention and reduce escalation into specialist pathways.

In addition to neurodevelopmental pathways, the Committee reviewed a number of key safeguarding concerns and discussed ongoing workforce challenges affecting service delivery. The Board noted the Committee's continued oversight of these issues and its focus on improving access, safety, and outcomes across the quality and performance portfolio.

The Board noted the report.

ICB/11/27/13 Highlight report of the Chair of System Primary Care Committee

Tony Foy presented the highlight report from the System Primary Care Committee. He advised that the committee had focused on two major areas: the GP Prescribing Risk and approach, and a range of quality concerns emerging within primary care services.

In relation to prescribing, Tony explained that the committee had been asked to undertake a deep dive involving primary care providers, which has now become a standing agenda item. At the most recent meeting, the ICB Chief Pharmacist, Susanne Lynch, delivered a detailed presentation and deep-dive analysis, supported by collaborative discussions with primary care contractors.

The Board also heard that the committee received an update from the Primary Care Quality Group, which highlighted issues related to the procurement of clinical waste services for community pharmacy and general practice. These concerns—along with associated contingency planning—were formally escalated to the Executive Committee for further action.

The Board noted the committee's continued scrutiny of prescribing risk, quality performance, and operational challenges within primary care, as well as its strengthened partnership working with providers and contracting teams.

The Board noted the report.

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ICB/11/27/14 Highlight report of the Chair of the Remuneration Committee

Tony Foy provided a verbal summary of the ICB Remuneration Committee report. This covered three meetings since the last Board meeting as follows:

17 October 2025 - the Pay Framework to be applied for the VSM positions within the proposed new Senior and Executive Leadership Team of the ICB was discussed and members approved the use of the existing national NHS VSM Pay Framework, adapted to reflect the new model ICB structure and strategic commissioning focus.

6 November 2025 – the committee received the draft Consultation document for the ICB Senior and Executive Leadership Team consultation. The Committee supported the progression of the consultation in line with the timeframes as outlined and that the ICBs Managing Organisational Change Policy would be observed.

17 November 2025 - received a paper on the proposed remuneration of the ICBs Interim Chief Executive position and approved the recommendation for the ICB Chair to be able to offer a salary that is within the Chief Executive salary range as outlined within the national VSM Pay Framework.

The Board noted the report.

ICB/11/27/15 Highlight report of the Chair of the Children's and Young People Committee

Chris Douglas Children's and Young People Committee provided a summary report from its meeting of 8 October 2025. Member were asked to take the report as read but highlighted two discussions from the meeting.

The Committee noted significant financial pressures and the need for system-wide consideration of social care budgets and advocacy access for children and young people. The urgency of developing a shared outcomes framework across partners was highlighted as a priority action.

The Health Equity Collaborative programme (CHEC) provided a presentation which emphasised the importance of capturing and acting on the voices of children and young people to inform system measures and priorities. This included personal testimony from attendees which highlighted improvements in children's speech, vocabulary, and engagement through monthly interactive book reading, reinforcing the value of early literacy and parental involvement.

The Board noted the report

ICB Business Items

ICB/11/27/16 Proposal regarding an Interim Sub-Fertility Clinical Policy across Cheshire and Merseyside

Fiona Lemmons introduced the interim sub-fertility clinical policy for consideration by the Board.

The purpose of the paper was to seek a decision on the policy following a period of public consultation, and appended to the report was an update on the work undertaken to date, an overview of the options appraisal presented at the May 2025 Board meeting, along with details of the Public Consultation outcomes, feedback from the Local Authority Health Oversight and Scrutiny Committees (HOSC) and updated post consultation Equality Impact Analysis.

Members were advised that this was one of several policies across C&M that required harmonisation to avoid the situation of a 'post-code' lottery. There was also a need to balance all the needs of all residents in C&M and to balance the books.

Four options were presented to the Board with Option 2 (to offer 1 cycle of treatment) being recommended for approval. This would offer the ICB an estimated £1.3m savings per year while

Agenda Item, Discussion, Outcomes and Action Points

maintaining access to fertility services equitably across C&M and brought us in line with neighbouring ICBs and 66% of all ICBs nationally.

Appendices to the report were extensive and included feedback from the public consultation. This showed that 86% of respondents disagreed or strongly disagreed with the proposed change to the number of IVF cycles that were funded. Members were asked to review the detailed responses to the questionnaire as appended.

Members were directed to the post public consultation Equality Impact Assessment (EIA) which highlighted that the proposal to offer patients one cycle of IVF could lead to indirect discrimination for certain groups and examples of these were given in the report.

Reference was made to the Public Sector Equality Duty (PSED) in a Financial Crisis and the Board was advised that Section 149 of the Equality Act 2010 was a continuous duty and was not suspended during a financial emergency. Members would need to balance decision taking these into consideration.

The interim policy had been considered and various Overview & Scrutiny (OSCs) fora during 2025 and the outcome from the Joint OSC was that it was not supportive of the preferred option as one cycle would not be in the best interest of residents across C&M. They further commented that if the Board's decision to harmonise the policy to 1 cycle was approved then it would be writing to the Secretary of State to 'Call-In' the decision.

During the ensuing discussions the following comments were received:

- that this was a highly emotive and challenging subject and made difficult reading.
- that it was imperative that the ICB adopted a single, harmonised policy
- acknowledged and thanked the team for the work undertaken in bringing the report to Board
- recognised that this was an interim policy that would be reviewed once the NICE guidance had been released in 2026
- noted the Board's duty to balance treatments for all residents in C&M within budget against the PSED
- reviewed the relevant success rates for treatment across the various cycles as detailed in the report
- a Board member's struggle with costs such as PWC consultants costing the ICB £5m versus direct patient care such as this
- that health inequalities could be exacerbated by the decision reached by the Board

Sir David put the proposed recommendation of the Executive Committee to the Board to adopt an interim clinical policy that offers patients in Cheshire and Merseyside 1 cycle of IVF treatment and requested that the vote be recorded.

For the record, votes in favour of the proposal were received from: Naomi Rankin, Adam Irvine, Janelle Holmes, Trish Bennett, Liz Bishop, Andrea McGee, Chris Douglas, Rowan Pritchard-Jones, Sir David Henshaw, Tony Foy, Ruth Hussey, Mike Burrows and Sue Lorimer.

Andrew Lewis and Delyth Curtis abstained from the vote.

The ICB Board approved the recommendation of the Executive Committee to adopt an interim clinical policy that offers patients in Cheshire and Merseyside 1 cycle of IVF treatment.

ICB/11/27/17 Safeguarding Our Workforce – NHS Cheshire and Merseyside Sexual Misconduct Policy

Mike Gibney provided an update on progress in implementing the NHS Sexual Safety Charter and the ICB's Sexual Misconduct Policy. He reminded the Board that the Charter sets out national expectations for promoting dignity, respect and safety across NHS workplaces. The Board was advised that NHS

Agenda Item, Discussion, Outcomes and Action Points

Cheshire and Merseyside had now ratified its Sexual Misconduct Policy, with assurance and oversight reported through the People Committee.

Mike highlighted that significant preparatory work had already been completed, including the establishment of trained Sexual Safety Allies, the rollout of an e-learning package, and the development of communications to raise awareness of reporting routes and behavioural expectations. The proposed governance and implementation plan includes leadership development, a train-the-trainer model, and alignment with regional domestic abuse and sexual safety arrangements. Chris Douglas will act as the Board-level lead for the programme.

The Board:

- Endorsed the governance and rollout plan for the Sexual Safety Charter
- Supported the leadership sponsorship and engagement arrangements
- Approved the integration of the Sexual Misconduct Policy into existing safeguarding and HR frameworks

ACTION:

Mike Gibney to share the ICB Sexual Misconduct Policy with higher education institutions via the deanery to ensure alignment with organisations placing students into NHS settings.

ICB/11/27/18 Proposed draft NHS Cheshire and Merseyside Board Assurance Framework Strategic Risks for the 2025-2028 period

Clare Watson presented the proposed 2025 - 2028 Board Assurance Framework (BAF), including the eight strategic risks identified for Board approval. She explained that the proposed risk appetite levels for each risk had been developed through engagement with Board Members and Executive Directors and benchmarked against similar risks featured in other ICB and provider BAFs.

The Board noted that the ICB's core risk appetite statement had not changed since 2023. Members were asked to consider whether this remained appropriate given the current operating environment. It was agreed that a Board risk appetite development session would be arranged to review this in more detail and determine whether revisions were required.

Clare proposed that quarterly BAF updates be brought to the Board, with each strategic risk aligned to the appropriate Board committee to enable subject-matter deep dives and strengthened assurance. Board members discussed the frequency of reporting, whether quarterly reviews would provide sufficient oversight, the scoring of risks, and the role of the Audit Committee in coordinating BAF scrutiny prior to Board meetings. These areas will be further considered through the upcoming risk appetite session.

The Board approved the 2025 - 2028 Board Assurance Framework and endorsed the proposed reporting and governance arrangements.

ACTIONS:

- Claire Watson to arrange a Board risk appetite session
- Fiona Lemmons and Janelle Holmes to meet to discuss risk P15 specifically

ICB/11/27/19 Cheshire and Merseyside Urgent Emergency Care Strategy

The Chair advised that this item has been removed from today's agenda and would be considered at the next Board meeting.

ICB/11/27/20 Cheshire and Merseyside Winter Planning 2025-2026

Anthony Middleton updated the Board following the Winter Planning 2025/26 paper discussed in September 2025, and discussed the significant pressures experienced in the previous year, together with the learning that informed the revised approach.

It was noted that analysis from last winter showed that systems maintaining hospital bed occupancy at or

below 92% prior to the festive period were better able to sustain urgent and emergency care performance, particularly ambulance response and handover times.

Weekly trajectories for bed occupancy had been produced by all providers, though one system required further support to enhance confidence in delivery.

The Board reviewed progress on staff vaccination rates, which had improved compared to the previous year, and acknowledged the importance of continued uptake in maintaining operational resilience.

Members also discussed the additional hospital, community and social care capacity that could be mobilised if required, supported by contingency funding and workforce plans. The Board welcomed the commitment from local authority leaders to provide senior-level support throughout the winter period.

During discussion, Members emphasised the importance of real-time operational intelligence, a more collaborative, problem-solving relationship with places and providers, and the need for oversight of corridor care, discharge activity and the impact of early flu and respiratory illness, which had emerged sooner than expected.

ACTION: Anthony Middleton confirmed that he would arrange for a weekly tracking bulletin to be provided to Board members.

The Board noted the update and endorsed the continued system-wide approach to managing winter pressures.

ICB/11/27/22 Closing Remarks and review of the meeting

The Chair asked attendees to provide any closing remarks and to review the meeting.

Members summarised that:

- the meeting agenda demonstrated the diverse and difficult decision that the ICB Board had to consider
- these decisions were taken in a meeting held in open, with the public in attendance
- further consideration was needed on switching the default position to decisions made in public as opposed to behind closed doors
- the scale and breadth of the ICB's work was huge
- there was great pressure to work together better with system partners and that organisations could not work in silos
- they would like a forward plan or Board timetable to help them better organise and to advise the public on upcoming strategic decisions

The Chair closed the meeting with positive comments around the progress made in relation to the provider collaborative.

ICB/11/27/23 Any Other Business

There was no additional business for consideration.

CLOSE OF MEETING

CONSENT ITEMS

The Board received and noted the items within the Consent Item section of the November 2025 Board.

ICB Board Meeting Action Log

Updated: **06.01.26**

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			ONGOING	
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 recommended to close the action
ICB-AC-106	27/11/2025	Board Assurance Framework	Risk P15 to be reviewed and consideration given to risk scores	Janelle Holmes and Dr Fiona lemmens	Mar-26	Ffollow on meeting being arranged, proposed amendments will come to March 2026 Board as part of scheduled BAF update	ONGOING	Board is recommended to close the action
ICB-AC-107	27/11/2025	Cheshire and Merseyside Winter Planning 2025-2026	A weekly tracking bulletin to be arranged to be provided to Board members.	Anthony Middleton	Jan-26	Information has been provided through committees, standing touchpoints and bespoke communication. Enhanced provision will be picked up through winter debrief	COMPLETED	Board is recommended to close the action

Meeting of the Board of NHS Cheshire and Merseyside

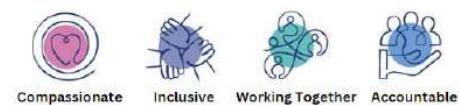
29 January 2026

Women's Hospital Services in Liverpool - Options Appraisal and Next Steps

Agenda Item No: ICB/01/26/09

REPORT SUMMARY SNAPSHOT

Required Information		Details		
Responsible Executive Director		Fiona Lemmens, Associate Medical Director, Deputy Medical Director		
Report approval		By	Fiona Lemmens	
		Date	21 January 2026	
Presented by		Fiona Lemmens, Associate Medical Director		
Ask of the Board		Approval	Decision	✓
		Endorsement	Ratification	
		Receive assurance	✓	Note
Route to Board – where has this report been discussed		Women's Services Committee, 12 November 2025		
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*		P4: Quality & Safety failures in commissioned services: P12: Failure to reduce health inequalities and improve population health P15: System Fragmentation and Provider Sustainability		
Financial Implications*		Yes	✓	No
		If Yes: Business case for option 2 in progress.		
		Have the financial implications been reviewed by the Director of Finance		
		Has a budget been identified		
Legal Implications*		Legal advice has been sought about engagement requirements and the governance and decision-making implications of these requirements are also highlighted.		
Conflicts of Interest associated with this report		N/A		
Impact assessments undertaken*		Equality		
		Quality		
		Data		
		Sustainability		
Public or Clinical engagement undertaken		A 6 week public engagement exercise was held for the case for change in late 2024. Clinical engagement has driven the programme and a dedicated Lived Experience Panel has been involved throughout.		



Women's Hospital Services in Liverpool - Programme Update

1. Executive Summary

- 1.1 The Women's Hospital Services in Liverpool Programme was established by NHS Cheshire and Merseyside to address the sustainability challenges and clinical risks in hospital-based gynaecology and maternity services in Liverpool.
- 1.2 This paper and supporting presentation (Appendix One) will cover the outcomes of the options appraisal process. This is being brought to board to enable informed discussion and agreement on next steps NOT a final decision. This is intended as a gateway so that the provider has approval to move to the next stage which would be the development of a business case for Option 2.
- 1.3 Legal advice has been sought about engagement requirements and the governance and decision-making implications of these requirements are also highlighted in Appendix Two.
- 1.4 An Equality Impact Assessment of the options considered to date is included with the papers (Appendix Three).

2. Ask of the Board and Recommendations

2.1 The Board is asked to:

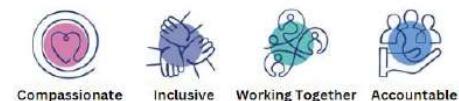
- Note the work completed to date and that all options for change have significant financial consequences for the C&M system
- Note that the Women's Services Committee was assured that the options process has been completed appropriately
- Note the Equality Impact Assessment of the options considered to date.
- Include a commitment to achieving the long-term sustainability of women's services within the ICB's medium term plan
- **Confirm support** for the proposed next steps for the programme which are:
 - the provider to produce a business case for Option 2
 - agree the process and indicative timescales for public engagement on option 2
 - engage with NHSE regarding support for achieving safe and sustainable women's services in the longer term.
 - consider the long-term solution in the context of wider strategic plans and the benefits for the Liverpool and C&M system.

3. Appendices

Appendix One: Update Presentation

Appendix Two: Option 2 Involvement and Governance

Appendix Three: Women's Hospital Services EIA Options Appraisal



29 January 2026
ICB Board Meeting
Agenda item: [ICB/01/26/09](#)

APPENDIX ONE

Update Presentation

Women's Hospital Services in Liverpool

Options Appraisal and Next Steps

29 January 2026

Introduction

The NHS C&M Women's Services Programme was established in 2023 following an independent review of hospital services in Liverpool.

The aim of the programme is to address the clinical risks currently present in gynaecology and maternity hospital services in Liverpool.

Following the development of a case for change, an options appraisal process has been completed which has assessed a range of options for dealing with the clinical risks.

The options have then been subject to high level estates and financial modelling, which has been reviewed by the Programme Board and presented to the Women's Services Committee in November 2025.

An Equalities Impact Assessment of the options has also been completed.

This presentation summarises the options work to date.

Engagement, governance and decision-making also need to be considered by the Board.

Clinical Risks the Programme is Seeking to Resolve



Risk 1 - Acutely deteriorating women cannot be managed on site at Crown Street reliably, which has resulted in adverse consequences and harm.

Risk 2 - Women presenting at other acute sites (e.g. A&E), being taken to other acute sites by ambulance, or being treated for conditions unrelated to their pregnancy or gynaecological condition at other acute sites, do not get the holistic care they need.

Risk 3 - Failure to meet service specifications and clinical quality standards in the medium term could result in a loss of some women's services from Liverpool.

Risk 4 - Recruitment and retention difficulties in key clinical specialties are exacerbated by the current configuration of adult and women's services in Liverpool.

Risk 5 - Women receiving care from women's hospital services, their families, and the staff delivering care, may be more at risk of psychological harm due to the current configuration of services.

These risks exist in the context of a significantly deprived population.

As the case for change demonstrated, women from deprived populations and ethnic minority groups are disproportionately affected by the current configuration of services.

Current Programme Timescales



Cheshire and Merseyside

Phase 1

(autumn 2024 - spring 2025)

Publish case for change

Carry out public engagement and analyse feedback

Start design work for potential future model of care

Phase 2

(spring - summer 2025)

Undertake more detailed design work

Clinical engagement to scope potential options

Options appraisal process

High level modelling for options

AUTUMN 2025 - TAKE STOCK

Phase 3

(winter 2025 – summer 2026)

The detail of what happens in Phase 3 will be determined by the outcomes of Phase 2 and the options that are developed.



Supported by the Lived Experience Panel



2014 - 2015

LWFT formally declares clinical sustainability issues in response to concern from clinical staff, and begins to plan future of city's health services for future generations of women and babies.

2016

LWFT and Liverpool CCG undertake a 'summer of listening' with patients and public to gather views about the future direction of services.

2017

LWFT identify a preferred option to co-locate with the RLH. Validated by an independent clinical senate. Trust demonstrates the availability and affordability of capital funding

2019

LWFT holds a clinical summit with NHS system partners to look at ways to reduce clinical risks, while still working on securing the preferred option.

2018

LWFT continues to apply for capital funding for the preferred option, while developing the current neonatal estate to keep babies as safe as possible.

2017

A draft business case is published by Liverpool CCG detailing future options with a preferred option of moving to a new Women's Hospital next to the new Royal Liverpool Hospital.

2019

NHS England convenes an urgent process with system partners to agree ways to reduce clinical risk while the preferred option is progressed.

2020

LWFT applies for capital funding to further reduce risk on site by bringing a CT scanner, robotic surgery and a blood bank to Crown Street.

2020

Plans to refresh the Future Generations business case are put on hold due to the COVID-19 pandemic. The government announce plans to build 8 new hospitals.

2023

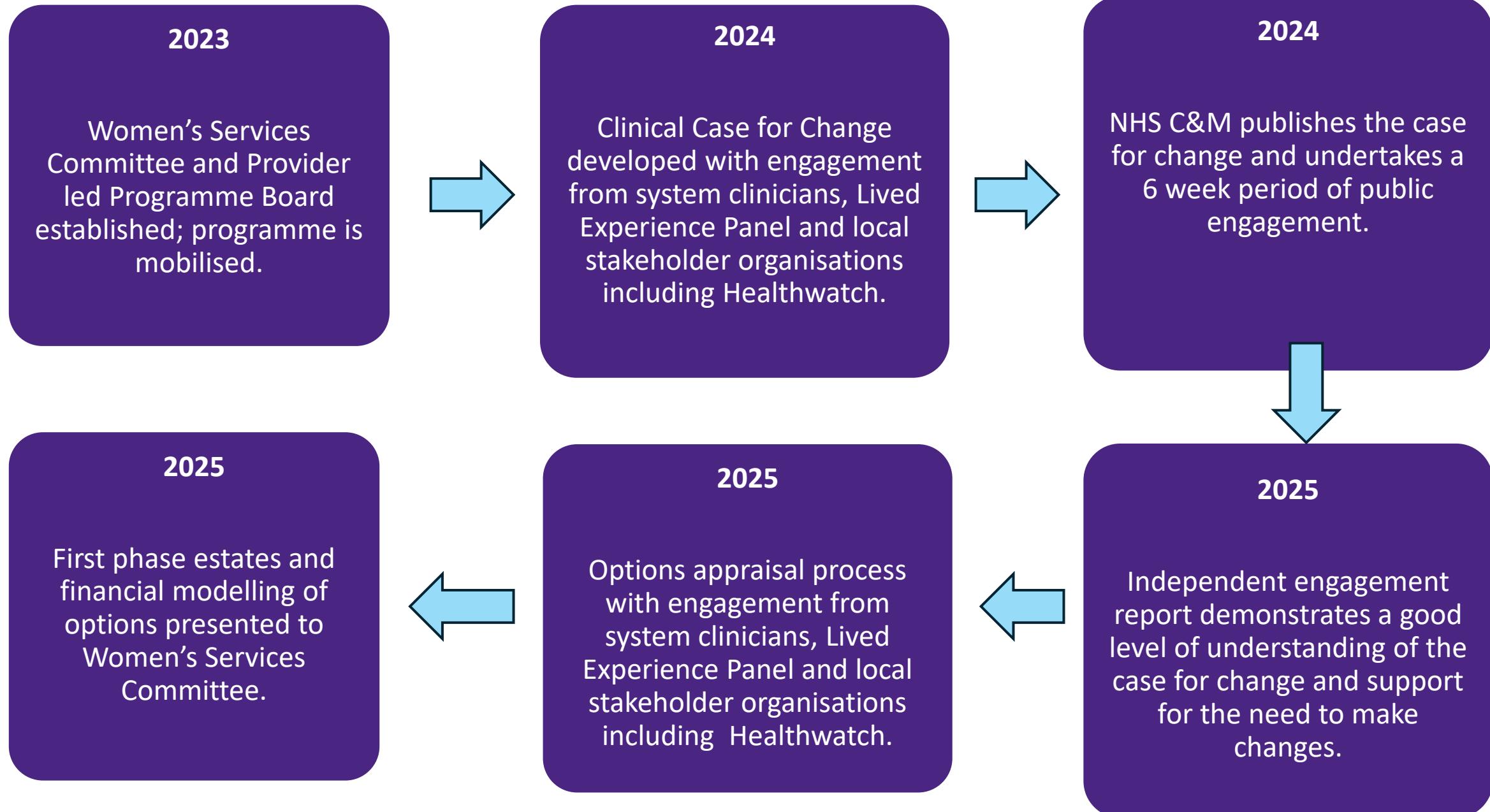
NHS Cheshire and Merseyside accepts the recommendations of the Liverpool Clinical Services Review and establishes the Women's Services Programme.

2022

LWFT refreshes the case for change and counterfactual case, begins refresh of business case and re-starts the service change assurance process with NHSE.

2021

LWFT submits an Expression of Interest to the new hospitals building programme



History of the Programme

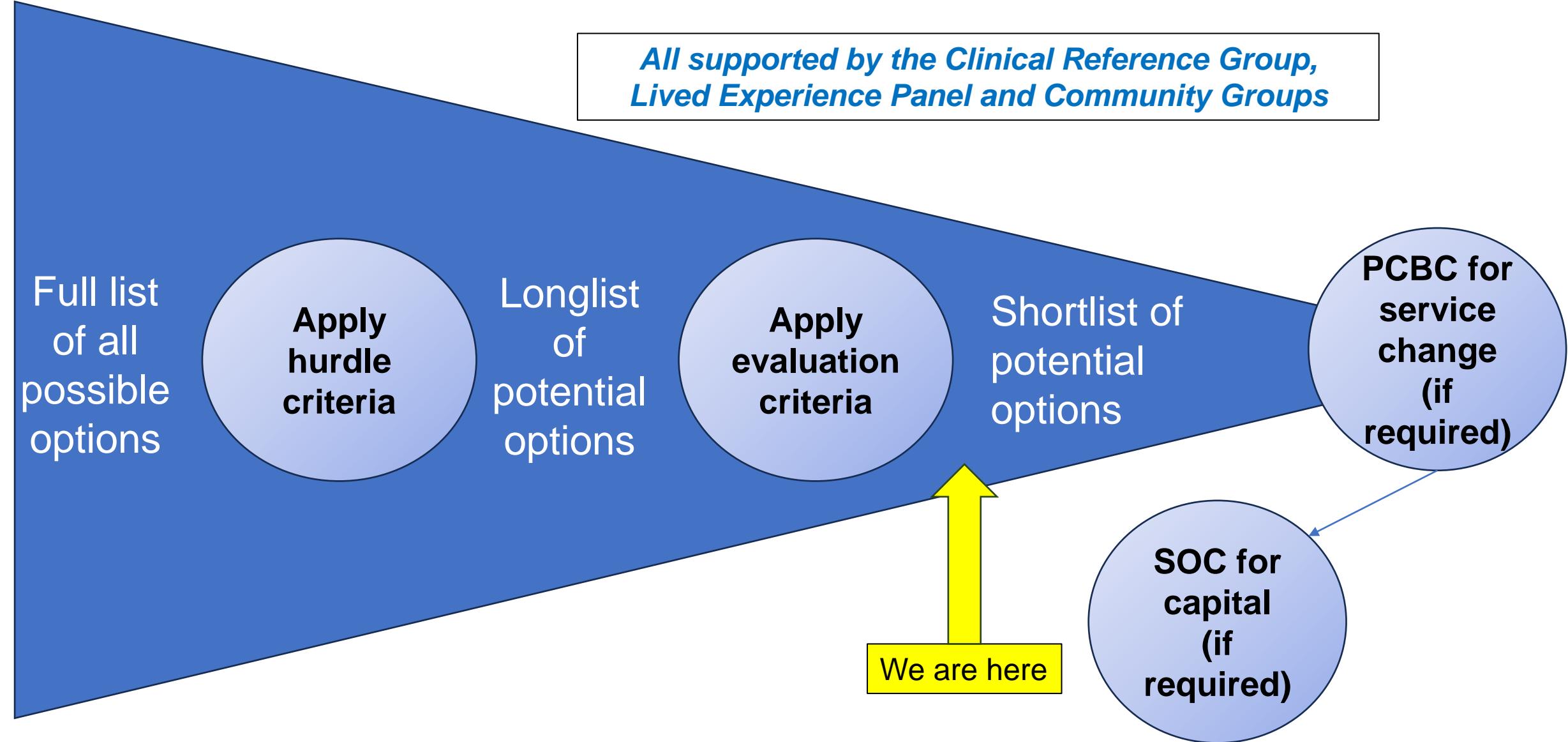
Case for change and options appraisal work has been completed four times since 2014/15 (x2 LWFT, x1 LCCG with external support from FTI Atkins, x1 by NHS C&M).

The preferred option has been the same each time – i.e. colocation of gynaecology, maternity and neonatal services on an adult acute site. This has been supported by published evidence on the colocation of acute hospital services (South East Clinical Senate).

There have been clinical senate reviews of the case for change and the counterfactual case; the case for change has been described as ‘compelling’ (North West and North East Clinical Senates).

There have been three ‘stage 1’ change assurance meetings with NHS England to present the strategic and clinical case for change; the issues are well understood at regional level.

Summary of the Options Process



“Short-er” List Descriptions

Option No	Service Scope	Model for Delivery
1	BAU / Counterfactual	<p>The status quo - services and clinical risks largely remain as they are.</p> <p>Includes ongoing annual service improvements at LWH.</p> <p>The counterfactual may come to pass with some loss of services and staff.</p>

RLH

1 day of operating per week – complex gynaecology and rare deliveries.
Critical Care.

LWH

The status quo – some specialist services may be at risk long term.

Aintree

Clinics, ad hoc outreach, rare deliveries

Option 2 – Do Minimum - Highest risk women and services co-located (integrated) on RL site - more services at all sites

RLH

More high risk women treated / cared for than option 1.

Defined group of high risk deliveries (circa 30 deliveries pa - surgical only - no choice to labour)

Neonatal presence for deliveries.

More high risk gynaecology surgery (75-100 cases pa).

Acute take review / support to ED.

LWH

Vast majority of gynaecology, maternity and neonatal remains.

Increased presence of acute specialties including critical care support for women requiring enhanced care.

Aintree

More clinics / acute take review / support to ED.

THIS IS THE ONLY VIABLE OPTION IN THE MEDIUM TERM

Option 2 – Key Service Details

6 bedded enhanced care unit, with improved facilities and accommodation, on the LWH site – cohorting 4 existing beds (2 maternity, 2 gynaecology) and 2 additional beds to accommodate future demand.

Appropriate accommodation and capacity (beds / theatres / critical care) provided at the RLH site for additional gynaecology operations and high-risk births. This would include additional neonatal support for births (staff, kit, transport).

Greater investment in obstetric physician time (from 1 day to 5 days p.w.)

Investment in visiting AHPs and therapist staff not currently provided for at LWH (e.g. OT, nutrition, SALT).

Investment in adult acute medical time to manage the required input to LWH (e.g. colorectal, urology, cardiology).

Consultants of the day (one for gynaecology and one for maternity) and increased consultants on call (gynaecology, maternity and neonatology) to enable cover at non-LWH sites (including attending EDs / completing ward rounds).

Increase outreach midwifery to 24/7 – for visiting non-LWH sites.

New role for outreach specialist gynaecology – for non-LWH sites – in particular for older women post op.

Dedicated ambulance resource for inter-site transfers.

Option 6a – All Inpatient Gynaecology, Maternity and Neonatology on RL Site – integrated into existing buildings

RLH

Critical Care.

All inpatient gynaecology – complex and non-complex.

24/7 non-elective gynaecology.

All inpatient maternity (obstetrics and midwifery) and neonatology.

Alongside midwifery led unit.

MAU.

LWH

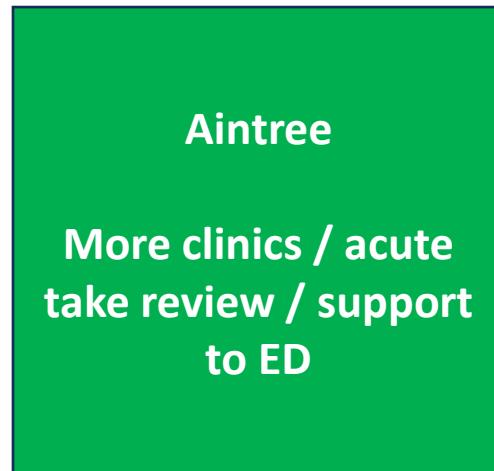
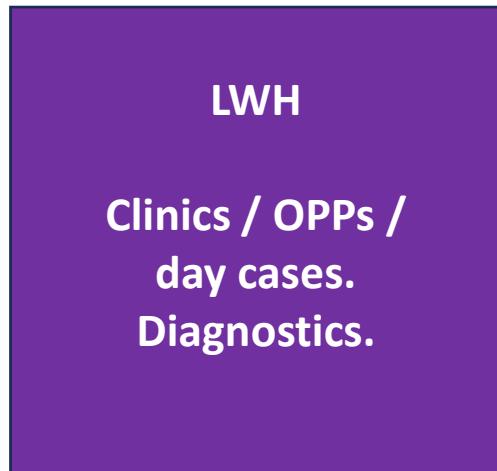
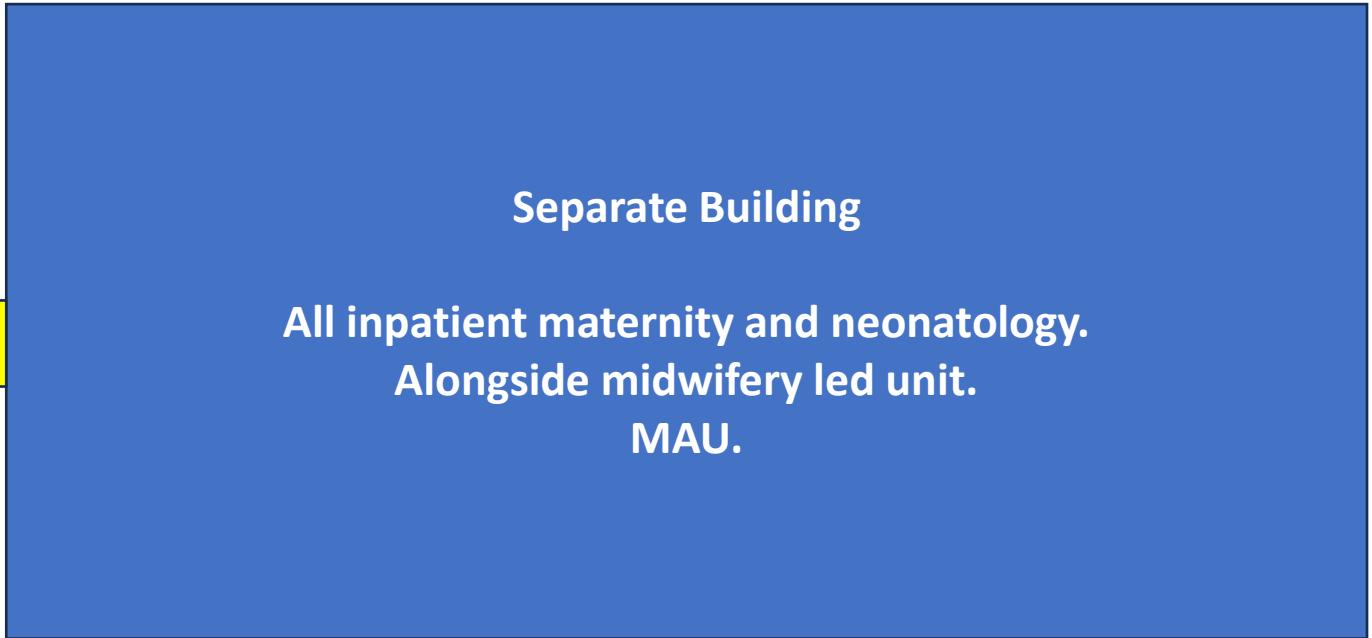
Clinics / OPPs / day cases.

Diagnostics.

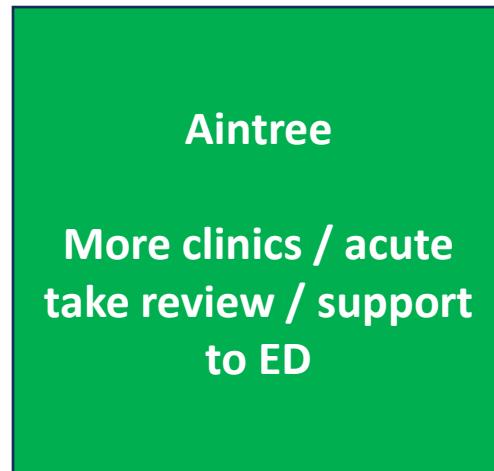
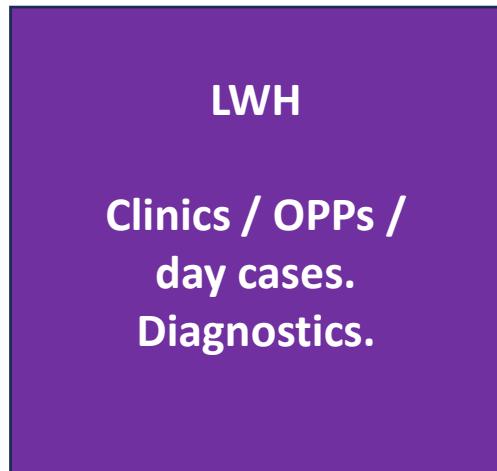
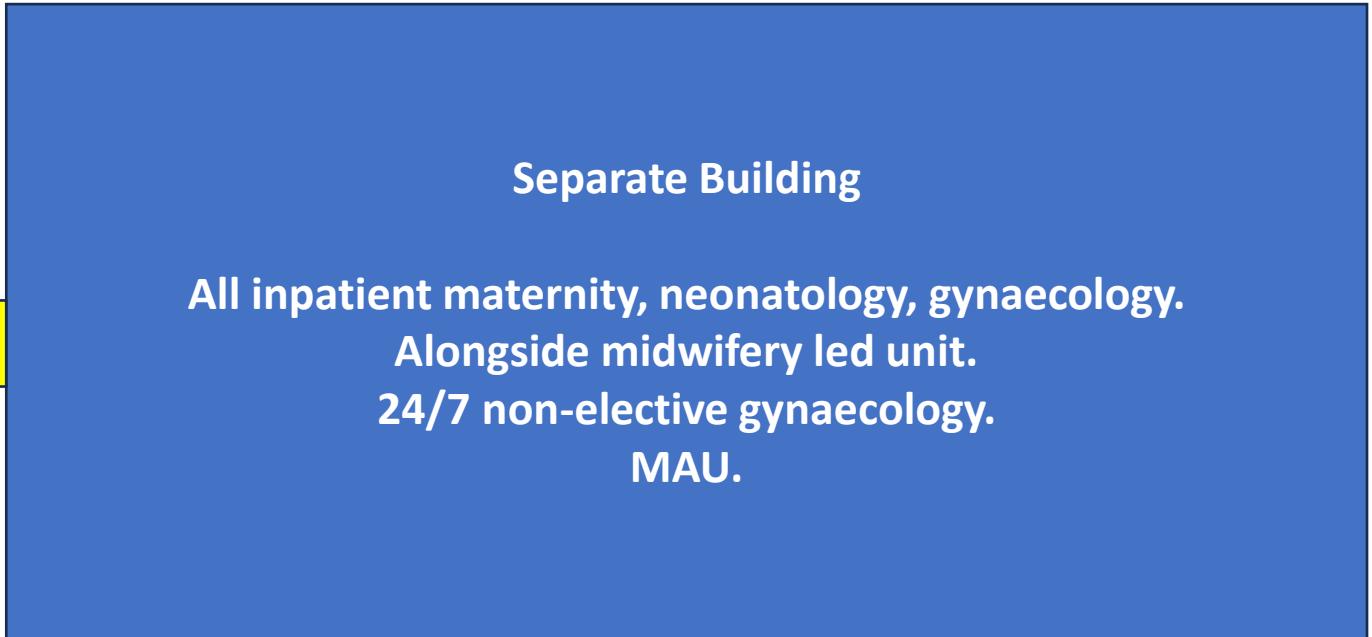
Aintree

More clinics / acute take review / support to ED.

Option 6b – Hybrid - All inpatient gynaecology integrated, maternity and neonatology on RL site in a separate building.



Option 6c – All inpatient gynaecology, maternity and neonatology on RL site in a separate building – Do Maximum



Long List Rankings from Workshop 2 – High Clinical Consensus

Option	Description	Table Number							
		1	2	3	4	5	6	7	8
1	Rank 1 = best Rank 6 = worst	6	6	6	6	6	6	6	4
2	Do Minimum - Highest risk women and services co-located (integrated) on RL site - more services at all sites	5	4	5	5	4	5	5	5
4	Co-locate all inpatient gynaecology and only highest risk maternity on RL site - integrated	4	5	4	4	5	4	4	6
SPLITS GYNAE AND MATERNITY EMERGENCY PATHWAYS - REMOVED AFTER WORKSHOP 2 FOLLOWING DISCUSSION WITH CLINICIANS & WSC									
6a	All Inpatient Gynaecology, Maternity and Neonatology on RL Site – integrated into existing buildings	3	3	3	3	3	3	3	2*
6b	Hybrid - All inpatient gynaecology integrated, maternity and neonatology on RL site in a separate building	2	2	2	1 *	2	2	2	2*
6c	All inpatient gynaecology, maternity and neonatology on RL site in a separate building – Do Maximum	1	1	1	1*	1	1	1	1

Option 6a – ‘test to fit’ exercise

The *test-to-fit* exercise for option 6a confirms that all major functional elements can be accommodated within the RLH estates envelope with some compromises.

Existing derogations within the RLH would need to be accepted e.g. there would be some compromises on standard room sizes (all single rooms are approximately 4sq.m. under sized) and there is no isolation provision on a typical ward.

For neonatal services:

- **A typical IC / HD cot space allowance is sized at 20sq.m. The test to fit exercise indicates a range of around 12sq.m. to 15sq.m.**
- **A typical special care cot space is around 11.5sq.m with a test to fit range of 8sq.m. to 11sq.m.**

The existing size and shape of the Royal Liverpool Hospital building would mean some services may need to be configured differently and / or require different staffing models e.g. maternity wards.

Structural and MEP (Mechanical, Electrical and Public Health) constraints – e.g. birthing pools, theatre ventilation and drainage on Level 9 would require further investigation in subsequent design stages.

Detailed design work would be required with clinical teams in order to test this option further.



Next Steps in the Development of Estates Options would be.....

- **Validation of Clinical Model:** Confirm final Schedule of Accommodation numbers and departmental adjacencies.
- **Technical Feasibility Studies (6a only):** Structural and MEP surveys, particularly for Level 9 birthing and theatre functions.
- **Illustrative Design Work:** For 6b and 6c as comparisons to 6a.
- **Cost Refinement:** Develop elemental cost plan and phasing allowances to improve accuracy.
- **Stakeholder Engagement:** Ongoing collaboration with clinical leads, estates, and infection control teams.

This would require a commitment to a project team and significant resources.



Conclusion

The conclusion of the options appraisal process is that co-location of inpatient gynaecology and maternity services with other adult acute services is the only way to resolve the risks.

Based on the high-level modelling to date all options have significant financial consequences.

Option 2

- would achieve co-location for a very small proportion of women using inpatient gynaecology and maternity services (less than 1%).
- is the only option viable in the short to medium term – it is clinically an improvement on the status quo - however - all the risks remain in full or in part.

Options 6a - 6c

- would achieve co-location for the vast majority of inpatient and emergency gynaecology and maternity services; the exceptions are those women presenting, or inpatient, at other sites.
- resolve the risks for the long term for the vast majority of women.

Without moving to Options 6a–6c, the most serious equality and health inequality risks for women and babies will remain.

Even in pursuing long term capital options, option 2 (or a version of option 2) would be required in the meantime.

Engagement, Governance and Decision-Making for Option 2

- Independent legal advice suggests that pursuing option 2 would still require a degree of public engagement.
- It is recommended that a 6 week period of engagement takes place in the summer 2026.
- Final decision making about changes in access (specifically high risk births and increased gynaecology operating at RLH) could take place in the autumn 2026.

Ongoing Risks & Issues

- The health inequalities present in these services will continue and ongoing population health issues make this more challenging e.g. obesity, increases in endometriosis, later pregnancies, poor health literacy.
- Clinical staff involved in these services continue to deliver services in a configuration that would not be tolerated elsewhere – with no clear long term commitment to change and ongoing risks to themselves and patients.
- The counterfactual case is still a real risk – could lead to diminution of services in Liverpool / C&M.
- The credibility of the ICB / NHS could be questioned if, having completed the work for a fourth time, there was no commitment to a long-term solution.
- There are business continuity risks for the outstanding work of the programme e.g. developing business case(s), management of the engagement programme for option 2.

Next Steps for the Programme

- The provider to produce a business case for Option 2
- Agree the process and indicative timescales for public engagement on option 2
- Engage with NHSE regarding support for achieving safe and sustainable women's services in the longer term.
- Consider the long-term solution in the context of wider strategic plans and the benefits for the Liverpool and C&M system.

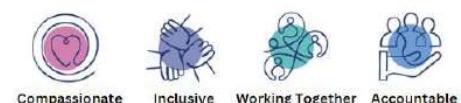
Recommendations to the Board

- Note the work completed to date and that all options for change have significant financial consequences for the C&M system.
- Note that the Women's Services Committee was assured that the options process has been completed appropriately.
- Note the Equality Impact Assessment of the options considered to date.
- Include a commitment to achieving the long-term sustainability of women's services in Liverpool within the ICB's medium term plan.

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APPENDIX TWO

Option 2 Involvement and Governance



Women's Hospital Services in Liverpool

Option 2 - Involvement and Governance Considerations

January 2026

Public involvement

NHS organisations, including ICBs and trusts, have a legal duty to involve the public, as set out in the National Health Services Act 2006, as amended by the Health and Care Act 2022 and detailed in NHS England's statutory guidance¹. Because option 2 would mean a change to the way that some patients access gynaecology and/or maternity care (as a result of the change of location), the duty to involve would apply. It is not stipulated how this duty should be met, so an assessment of the most appropriate involvement mechanism, which is effective, proportionate and minimises the potential for legal challenge, is required.

NHS Cheshire and Merseyside's communications and engagement team has taken initial legal advice to explore involvement considerations around progressing option 2. This covered the following points:

- The number of patients potentially impacted by option 2 is likely to be relatively low, which might in other circumstances indicate a smaller scale, targeted approach. However, because of the level of interest in women's hospital services in Liverpool, a wider, more formal public involvement process would reflect the commitment of NHS partners to both transparency, and engaging with the local population ahead of any final decision-making.
- While the means of involvement is not prescribed in national guidance, given that the future of women's services in Liverpool is a long-standing issue, attracting significant interest, it is suggested that engaging with the public on the option 2 proposal ahead of decision-making would offer a robust way of meeting involvement requirements.
- The process would also provide an opportunity to explain how the programme of work reached this point, how option 2 emerged from the options process, and intentions for the longer term.
- It would be important to be clear about the fact that option 2 would not mitigate all of the clinical risks previously outlined, and that additional future public involvement would be required if further proposals (i.e. around relocation of services) were put forward.

It is suggested that a plan for a six-week public engagement should be put to the ICB Board (in public), with the intention of launching this activity the following week (subject to Board approval). This would set out the proposed change and give people an opportunity to respond with their views. Feedback received would then be analysed and set out in a report to inform final decision-making.

¹ <https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/>

Both commissioners and providers are subject to public involvement duties², but they can work together to discharge these requirements. Delivery of the six-week autumn 2024 engagement around the case for change (*Improving Hospital Gynaecology and Maternity Services in Liverpool*), was overseen by the NHS Cheshire and Merseyside communications and engagement team, with specialist external support around analysis and reporting.

Potential governance timescales and phasing

The following is an overview of the likely governance process required to move forward with option 2 – including delivering public involvement – and the timing implications.

Steps required:

1. ICB board discussion to receive outcomes of options appraisal process and agree next steps (January 2026).
2. (Subject to board agreeing to proceed to public engagement) Board to receive public engagement plan for option 2 proposal.
3. (Subject to board approval of engagement plan) Launch of six-week public engagement. A minimum of one month will be required on close of process to produce feedback report.
4. Business case and feedback report presented to public ICB board for final decision-making.

Subject to discussions with local authorities (at the conclusion of step 2), an overview and scrutiny process might also need to be factored in to timescales.

Local elections take place on Thursday 7 May 2026 in Knowsley and Sefton – Liverpool's next elections are in 2027. Guidance suggests that NHS organisations should not launch engagement activity during the pre-election period, which is usually observed for six weeks beforehand i.e. from around 26 March 2026. Taking this into account, it is suggested that public engagement could take place during summer 2026, with final decision-making in autumn 2026.

ENDS

² section 14Z45 of the National Health Services Act 2006, as amended by the Health and Care Act 2022 for integrated care boards; section 242(1B) for NHS trusts and NHS foundation trusts.

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APPENDIX THREE

Equality Impact Assessment

Equality Impact Assessment

Women's Hospital Services in Liverpool Programme – Options Appraisal

December 2025.

1. Problem and Overview

The Women's Hospital Services in Liverpool Programme seeks to develop a clinically and operationally sustainable model of care for hospital-based gynaecology and maternity services in Liverpool. The current configuration at Liverpool Women's Hospital (LWH), as a standalone site, creates clinical and workforce risks because it is physically separated from other acute adult services. This separation can delay access to emergency, surgical and critical care support for women and babies and can lead to multiple inter-site transfers. These risks are not evenly distributed and contribute to unequal outcomes for specific groups of women and babies.

The purpose of the options appraisal was to identify viable models of care that reduce these risks, improve safety and outcomes, and address underlying health inequalities, while maintaining or improving patient and staff experience. This Equality Impact Assessment (EIA) considers the impact of each of the current options on people with protected characteristics and on groups experiencing health inequalities, as required by the Public Sector Equality Duty and wider NHS duties on health inequalities.

2. Services Under Review

Liverpool Women's Hospital provides maternity, gynaecology and neonatal services for Liverpool and surrounding areas, serving a diverse population across multiple local authority areas. Services include antenatal, intrapartum and postnatal maternity care, gynaecology emergency and elective care, and neonatal intensive and special care.

The programme is guided by a number of principles, including: that the Crown Street site will not close; that maternity and neonatology must be co-located; that maternity services must have access to emergency gynaecology and critical care support; and that elements of the agreed future model of care should be deliverable across all viable options, subject to investment and implementation planning.

The future model of care in all options is expected to include: increased clinician presence across acute sites, supported by digital and telemedicine; improved emergency pathways and inter-site transfers; better access to diagnostics and allied health professionals; a focus on reducing health inequalities and delivering culturally appropriate, holistic care; enhanced access including seven-day, digital and outreach models; unified records and shared electronic systems; and a sustained commitment to staff wellbeing, training and inclusive leadership.

3. Options Under Appraisal and Comparative Equality Analysis

The options considered in this EIA are the status quo and four potential future configurations. This section first sets out a high-level comparative equality and health inequalities assessment across all options, followed by more detailed narrative for each individual option.

3.1 Differential Equality Impact Across Options

Dimension	Option 1 – Status Quo / BAU	Option 2 – Investment in services at existing sites (Do Minimum)	Option 6a – Gynaecology, maternity and neonatal services integrated into the RLH (existing estate)	Option 6b – Hybrid – integrated gynaecology and a new maternity and neonatal building on RLH site	Option 6c – A new gynaecology, maternity, and neonatal building on RLH site (Do Maximum)
Access to MDT and critical care	Weakest. Structural separation from adult acute services and critical care; delayed escalation remains.	Improved for a defined high-risk cohort but unchanged for the majority of women and babies.	Strong. All inpatient gynaecology, maternity and neonatology on the RL site with co-dependencies met.	Strong. Clinical co-location is achieved with a separate women's building linked to RL.	Strongest. Full co-location of women's inpatient services with optimal adjacency to critical care and diagnostics.
Fragmentation and transfers	High. Frequent ambulance transfers and embedded fragmentation create equality and safety risks.	Moderate. Transfers reduced for high-risk cases only; fragmentation persists for most women.	Low. All inpatient and emergency services integrated in the building but spread across the hospital.	Low. Pathways are clearer, although early pregnancy navigation requires careful design.	Lowest. Dedicated inpatient women's footprint and minimal transfers; simplest model to navigate.

Women-only safe space and trauma-informed environment	Mixed. Standalone women's site is positive but estate limitations and clinical isolation create risks.	Mixed. Some high-risk women benefit from RL environment but fragmentation and separation remain for many.	Weakest. Integrated RL estate may limit the ability to provide protected women-only space and increase risk of outliers.	Stronger. Separate maternity and neonatal building supports women-only space and trauma-informed design.	Strongest. Dedicated women's building offers best opportunity for trauma-informed, culturally safe environments.
Estate and accessibility (including AIS and disability access)	Constrained. Ageing Crown Street estate; improvements are possible but structural limitations remain.	Constrained for most women, as the majority still use the existing LWH estate.	Constrained. Re-use of RL estate limits ability to guarantee accessible entrances, protected beds and quiet spaces.	Better. New maternity and neonatal building provides greater flexibility to embed accessible design.	Best. Purpose-built women's facility allows universal design, AIS by design and clear wayfinding.
Impact on Core20, ethnic minority and other high-inequality groups	Adverse. Deprived and ethnic minority women continue to face higher risks within a fragmented model.	Partially positive. Improved safety for a minority; limited change for most women and babies.	Positive but limited by estate and environmental constraints.	Strongly positive. Major reduction in structural health inequalities (for maternity), subject to effective design. Gynaecology limitations as for 6a.	Strongest positive. Best model to reduce structural maternal health inequalities at scale.

Overall equality and health inequalities impact (pre-mitigation)	Adverse.	Partial improvement with limited reach.	Substantial clinical improvement with mixed experience impacts.	Major improvement.	Transformational improvement.
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3.2 Option Narratives

Option one. Status Quo and Annual Service Improvements

Under Option 1 the current configuration at Liverpool Women's Hospital is maintained, with no major reconfiguration of service locations. Service improvement is limited to incremental changes through quality improvement and workforce initiatives. There are no significant capital costs or estate changes and the existing hospital identity and continuity for service users are preserved.

From an equality perspective, the structural risks associated with separation from adult acute and critical care services remain. Complex and high-dependency women and babies continue to rely on inter-site transfers, and workforce and recruitment challenges are likely to persist. This presents an ongoing risk of unequal outcomes for women from deprived areas, ethnic minority communities, older mothers and disabled women. Option 1 does not offer a credible route to systematically narrowing health inequalities or reducing the risk of indirect discrimination.

Option 2. Do Minimum: Highest Risk Women Cared for at Royal Liverpool

Under Option 2 most services remain at Liverpool Women's Hospital. A defined group of high-risk maternity and gynaecology patients receive planned care and delivery at the Royal Liverpool Hospital, where higher-level critical care and neonatal presence are available. This includes a limited number of high-risk gynaecology cases and high-risk deliveries each year. The model is supported by a consultant of the day approach, enhanced care at LWH, strengthened on-call and outreach arrangements and better cross-site transport and information sharing.

Option 2 delivers measurable equality benefits for a small group of women with the greatest clinical risk, such as older mothers, disabled women and those with complex medical conditions. However, the majority of women continue to experience the existing structural limitations associated with the standalone LWH site. Fragmentation and inter-site transfers remain a feature of care. While Option 2 can be justified as an interim improvement for the highest-risk cohort, it does not resolve the underlying structural inequalities for most women and babies.

Option 6a. All Inpatient Gynaecology, Maternity and Neonatology integrated into the Royal Liverpool Hospital (Existing Estate)

Option 6a locates all inpatient gynaecology, inpatient maternity and neonatology on the Royal Liverpool site, using existing RLH buildings. Liverpool Women's Hospital (Crown Street) retains outpatient, day case and diagnostic functions, and Aintree provides additional clinics and acute review. This model enables access to critical care, medical and surgical multidisciplinary teams and reduces inter-site transfers.

Clinically, Option 6a represents a substantial improvement in safety for all women and babies, by ensuring timely access to co-located specialist and critical care services.

From an equality perspective, however, substantial risks arise from the use of a general

acute estate. Workshop feedback indicates the risk that women's services could be absorbed into a very busy hospital environment with limited ability to provide dedicated women-only spaces, protected beds and trauma-informed environments. This is particularly important for women with a history of trauma or domestic abuse and for women from communities where modesty and gender-sensitive care are central to their religious or cultural practice. Estate constraints may also limit the ability to deliver fully accessible layouts and quiet sensory spaces. Option 6a significantly improves structural clinical equality but introduces new experience-based equality risks which would need to be considered as part of the detailed design work.

Option 6b – Hybrid: Inpatient and Emergency Gynaecology Integrated in the RLH, Maternity and Neonatology in Separate Building on Royal Liverpool Site

Option 6b places all inpatient and emergency gynaecology within the RLH and creates a separate maternity and neonatal building on the RL site, linked to RLH by a bridge. Liverpool Women's Hospital (Crown Street) continues to deliver outpatient and day case activity and Aintree provides clinics and emergency support. This approach maintains full access to critical care and multidisciplinary teams while allowing maternity and neonatal services to be housed in a distinct environment.

From an equality perspective, Option 6b offers major benefits. It reduces fragmentation for all women requiring inpatient care, improves access to specialist input and makes it easier to deliver women-centred, trauma-informed spaces within the separate maternity and neonatal building. There remains some risk of confusion in early pregnancy pathways and some limitations associated with integrating inpatient gynaecology within the general RLH estate. These risks can be mitigated through clear navigation, pathway design and safeguarding arrangements. Overall, Option 6b represents a high-performing model from an equality and health inequalities perspective.

Option 6c – All Inpatient Gynaecology, Maternity and Neonatology in a Separate Women's Building on Royal Liverpool Site (Do Maximum)

Option 6c brings all inpatient maternity, gynaecology and neonatology together within a dedicated women's building on the Royal Liverpool site. The building is linked to RLH for critical care and diagnostics but is separate from the main RLH estate. Liverpool Women's Hospital (Crown Street) continues to provide outpatient and day case services and Aintree provides additional clinics and emergency support.

This is the strongest option from an equality and health inequalities perspective. It minimises inter-site transfers and fragmentation, offers the clearest and simplest inpatient model for women and babies and provides the greatest flexibility to design a women-centred, trauma-informed, culturally safe and accessible environment. A dedicated women's building allows universal design principles to be embedded from the outset, including enhanced disability access, sensory-friendly spaces, clear wayfinding and women-only areas. It also supports the continuation and development of a women-centred culture and staff identity. Residual equality issues relate mainly to

implementation risks, such as affordability, detailed design choices and workforce planning, rather than the structural limitations of the option itself.

4. Equality Analysis

4.1 Population Profile

Analysis of Case for Change data, performance information and local Joint Strategic Needs Assessments indicates that women using LWH services experience high levels of deprivation and multiple intersecting inequalities. A significant majority of women using emergency gynaecology and maternity services live in the most deprived areas. A substantial proportion are from ethnic minority backgrounds and a notable proportion have a primary language other than English. There is also a regular flow of referrals related to significant mental health conditions, learning disability and domestic abuse.

The current configuration therefore has a disproportionate impact on women who already experience poorer health outcomes and barriers to access. Any option that fails to address structural safety and accessibility issues carries a risk of perpetuating and widening these inequalities.

4.2 Differential Impact by Protected Characteristic (Summary)

Age

Older mothers and those with co-morbidities are particularly vulnerable to delays in access to critical care and multidisciplinary support. Option 1 presents the highest risk. Option 2 reduces risk for a small defined cohort. Options 6a, 6b and 6c substantially improve safety for older women, with 6b and 6c offering the most consistent benefit across all inpatient pathways.

Young women may be more affected by digital exclusion, stigma, continuity of emotional support and the complexity of navigating multiple sites. Option 1 leaves these factors largely unchanged. Option 2 offers some improvement through enhanced outreach, but fragmentation remains. Options 6b and 6c provide the best platform for building youth-friendly, well-signposted services with integrated emotional and psychosocial support.

Race and ethnicity

Women from ethnic minority communities face higher baseline risks of maternal morbidity and mortality and may experience barriers related to language, cultural safety and trust. Option 1 does not address these structural issues and therefore carries a high risk of unequal outcomes. Option 2 improves outcomes only for a minority. Options 6b and 6c, if combined with strong anti-racist practice, interpretation support and community engagement, provide the best opportunity to reduce ethnic inequalities.

Disability, including physical, sensory and learning disability and neurodivergence

The current configuration and aging estate make it harder to consistently deliver

accessible environments, coordinated care and reasonable adjustments. Option 2 improves coordination for a small cohort. Option 6a improves clinical safety but the integrated RLH environment may be challenging for some disabled women. Options 6b and 6c allow more deliberate universal design, including accessible layouts, signage and quiet or sensory-friendly spaces.

Gender reassignment and non-binary identities

The principal risks relate to documentation, misgendering, lack of visibility and reluctance to seek care. These risks are present under all options. Options involving new pathways and estates (particularly 6b and 6c) provide an opportunity to embed inclusive forms, recording systems and staff training from the outset, but this depends on implementation rather than configuration alone.

Religion or belief

Women from some faith groups may require women-only spaces, sensitivity around modesty and gender-concordant care and access to appropriate prayer and dietary arrangements. Option 1 and 2 provides a standalone women's site but is constrained by estate and structural safety issues. Option 6a may compromise women-only safe space within a busy integrated estate. Options 6b and 6c provide the best opportunity to design women-only areas, appropriate entrances and culturally sensitive environments.

Sexual orientation

Across all options there is a risk that lesbian, gay and bisexual women and same-sex parents and patients (for gynae) are rendered invisible by heteronormative assumptions. This relates mainly to staff culture, documentation and training. Options that involve new buildings and redesigned pathways create an opportunity to embed inclusive signage, language and family-friendly spaces.

Pregnancy and maternity

All pregnant women and new mothers are affected by structural risks in the current model, but women from deprived areas and ethnic minority groups are more likely to experience adverse outcomes. Option 1 retains the highest risk configuration. Option 2 improves outcomes for a minority but leaves most women exposed to the same structural challenges. Options 6a, 6b and 6c reduce clinical risk for all women, with 6b and 6c providing the greatest opportunity for co-located, safe and dignified care for women and babies.

Intersectionality

Women who sit at the intersection of multiple risk factors, such as Black disabled women, young ethnic minority women living in poverty, and older LGBT+ women with faith needs, are disproportionately affected by the current model. Option 1 carries the highest intersectional risk. Option 2 provides only partial relief. Options 6a, 6b and 6c, if combined with targeted universalism and co-designed mitigations, are best placed to address intersectional disadvantage.

5. Public Sector Equality Duty and Health Inequalities Duty

5.1 Eliminate Unlawful Discrimination, Harassment and Victimisation

Option 1 maintains a configuration that has generated safety concerns and unequal outcomes for women and babies, especially those in deprived areas and from ethnic minority backgrounds. It carries a high ongoing risk of indirect discrimination by perpetuating structural barriers to timely and appropriate care.

Option 2 offers partial mitigation by improving outcomes for a defined high-risk cohort but leaves the majority of women in the same structurally risky inpatient environment. It therefore reduces discrimination risk only in a limited way.

Options 6a, 6b and 6c all reduce the risk of discrimination arising from delays in access to critical care and fragmented pathways. However, Option 6a introduces new risks associated with potential loss of dedicated women-only space and the potential for outliers in mixed environments. Options 6b and 6c provide the strongest basis for eliminating indirect discrimination by combining structural safety improvements with women-centred design.

5.2 Advance Equality of Opportunity

Advance equality of opportunity requires the ICB to remove or minimise disadvantage, meet different needs and encourage participation in public life. Option 1 does not offer a credible mechanism for systematically narrowing gaps in outcomes for women who are already disadvantaged.

Option 2 advances equality of opportunity for a small number of women by improving care for those with the highest risk, but its benefits are limited in scale. Options 6a, 6b and 6c, particularly 6b and 6c, allow meaningful reductions in structural inequality by ensuring all women requiring inpatient care have access to co-located specialist and critical care services. If combined with robust data collection, anti-racist practice, accessible information and integrated mental health and safeguarding support, these models can materially advance equality of opportunity.

5.3 Foster Good Relations Between Different Groups

All options require ongoing engagement with diverse communities and transparent communication about the reasons for change, the constraints and the proposed mitigations. Inclusive public consultation, co-production with service users and voluntary and community sector partners and clear feedback on how views have influenced decision-making will be essential.

Options involving new or redesigned estate (notably 6b and 6c) provide a visible opportunity to demonstrate investment in women's health and to rebuild trust, provided that consultation is accessible and that the voices of those most affected by inequalities are central to the process.

6. Recommendations from an Equality and Health Inequalities Perspective

First, Option 1 should not be regarded as a viable long-term solution. It maintains a structural configuration associated with unequal outcomes and does not enable the ICB to demonstrate due regard under the Public Sector Equality Duty and the Health Inequalities Duty.

Second, Option 2 can be justified as an interim improvement for a minority of women with the highest clinical risk, but it is insufficient as a long-term model. It does not address the structural issues that drive inequalities for the majority of women and babies using the service.

Third, Options 6a, 6b and 6c all represent a significant equality improvement on the current configuration. Option 6a delivers substantial clinical safety benefits but is constrained by estate and environmental factors that limit its ability to fully deliver women-centred, trauma-informed and accessible care.

Fourth, within the six-series options, Option 6c provides the strongest overall equality and health inequalities benefit. It offers the best opportunity to remove structural barriers to equitable maternal and gynaecological outcomes and to embed an inclusive, accessible and women-centred environment. Option 6b is a high-performing alternative where affordability or site constraints limit the feasibility of Option 6c.

Fifth, regardless of the preferred option, the programme should commit to a set of system-wide equality actions, including robust data monitoring by protected characteristic and deprivation, investment in inclusive training and leadership, delivery of the Accessible Information Standard, strong interpretation and communication support, and integrated mental health and safeguarding pathways. (See Appendix A)

7. Conclusion

From an equality and health inequalities perspective, the analysis indicates that Option 1 is associated with a high level of ongoing risk and should not be adopted as a long-term solution. Option 2 provides incremental improvement for a limited group of women but does not address the structural causes of inequality. Options 6a, 6b and 6c all improve clinical safety and reduce fragmentation. Option 6a carries residual equality risks linked to the use of existing estate. Options 6b and 6c, and particularly Option 6c, provide the best opportunity to meet statutory equality and health inequalities duties in a sustainable way.

The key determinant of equality impact will ultimately be how effectively the chosen model is implemented, including the extent to which women and communities experiencing the greatest inequalities are involved in design, decision-making and ongoing review.

8. Next Steps

Use this Equality Impact Assessment to inform any future business case(s) and ensure that equality and health inequalities considerations are explicitly reflected in the options appraisal and recommendations to the relevant committees and the Board.

Develop and implement an inclusive public consultation plan that actively reaches women and families most likely to be affected by change, including those in the most deprived neighbourhoods, ethnic minority groups, disabled women, young mothers, LGBTQ+ parents and women from different faith communities.

Following a decision on the preferred option, finalise and implement a detailed equality risk register and action plan, using the existing Appendix A framework, to track mitigations during design, construction and operational phases. This should include clear governance, timescales and responsibilities for monitoring and review.

Andy Woods

Senior EDI Lead

Appendix A – Equality Risk Register (Summary)

A protected characteristics-specific risk register has been developed to support Options 1, 2, 6a, 6b and 6c. It sets out key risks, affected groups and proposed mitigations and should be maintained as a live document as the programme progresses. Option-specific notes should be added to capture particular issues, such as the risk of outliers and loss of women-only space under Option 6a and the enhanced estate-based mitigations available under Options 6b and 6c.

Age

Risk	Specific Mitigation	Timescale	Risk Owner	Reporting Committee	RAG
Older women (35+) face elevated medical risks but may not receive age-appropriate monitoring when presenting at non-specialist sites	Consultant of the Day ensures rapid specialist assessment; enhanced on-call provides 24/7 expertise; acute specialty support manages complications on-site; training addresses age-related stigma; dashboard monitors outcomes				
Young women face dismissive attitudes and feel unheard, especially at general A&E	Specialist O&G advice to A&E staff; outreach provides continuity; training on youth engagement; safe spaces designed for young mothers; feedback mechanisms capture concerns				

Race & Ethnicity

Risk	Specific Mitigation	Timescale	Risk Owner	Reporting Committee	RAG
<p>Black women 2.8x more likely to die; Asian women 1.7x more likely - disparities persist regardless of socioeconomic status</p> <p>26% of service users from ethnic minority backgrounds; language barriers compromise safety</p>	<p>All actions work together to reduce systemic racism: rapid specialist response, continuous care, ambulance protocol to appropriate destination, anti-racism training, interpreter services, data monitoring, mental health support</p> <p>Anti-Racism Hub – clinical and non-clinical responding to reports of racial discrimination in patient care and patient outcomes including MNSIs</p> <p>Appropriate use of the bilingual volunteers.</p> <p>Consider up skilling bilingual volunteers to provide appropriate support</p>				

Risk	Specific Mitigation	Timescale	Risk Owner	Reporting Committee	RAG
	<p>Unified records document language needs; professional interpretation 24/7; translated feedback forms</p> <p>Appropriate use of the bilingual volunteers.</p> <p>Consider up skilling bilingual volunteers to provide appropriate support.</p>				
Women report dismissive attitudes, stereotyping, racial abuse, and microaggressions	<p>Outreach builds trust; comprehensive anti-racism training; safe spaces; staff support to address workforce discrimination</p> <p>Anti-Racism Hub – clinical and non-clinical responding to reports of racial discrimination in patient care and patient outcomes including MNSIs</p> <p>Appropriate use of the bilingual volunteers.</p>				

Risk	Specific Mitigation	Timescale	Risk Owner	Reporting Committee	RAG
	Consider up skilling bilingual volunteers to provide appropriate support				

Religion or Belief

Risk	Specific Mitigation	Timescales	Risk Owner	Reporting Committee	RAG
Religious practices (female clinicians, modesty, dietary needs) not accommodated when at non-specialist sites	Unified records document requirements; protocols embed religious accommodations; dietetics support; dedicated spaces for prayer/modesty				
Women feel judged when expressing cultural/religious needs, leading to delayed care	Specialist consultant understands diverse needs; outreach builds trust; cultural competency training; interpreter for sensitive discussions				

Disability

Risk	Specific Mitigation	Timescale	Risk Owner	Reporting Committee	RAG
Higher odds of stillbirth/neonatal death, C-section, longer hospital stays when care is fragmented	Specialist input across sites; on-call expertise; documented adjustments in unified records; complex needs managed on-site; AHP support; outcomes monitored				
Inaccessible facilities and communication when presenting at non-specialist sites	Records document communication needs; speech/language therapy; accessible safe spaces; multiple feedback formats				
18.2 admissions/month for neurodivergence; 10.7 for learning disability - staff lack training	AHP support for communication; disability awareness training; staff wellbeing to maintain quality				

Gender Reassignment

Risk	Specific Mitigation	Timescales	Risk Owner	Reporting Committee	RAG
Misgendering and deadnaming common when transferred between sites; cisnormative language and forms	Unified records with correct name/pronouns; inclusive protocols; LGBTQ+ training; gender-neutral safe spaces; accessible feedback				
Gender dysphoria triggered by pregnancy and gendered procedures, especially at unfamiliar sites	Specialist consultant aware of trans health needs; outreach provides continuity; integrated mental health support				
Discrimination and lack of provider knowledge at emergency sites	Comprehensive training for all staff including A&E; staff support networks				

Sexual Orientation

Risk	Specific Mitigation	Timescales	Risk Owner	Reporting Committee	RAG
Heteronormative assumptions exclude same-sex partners when women present at A&E or other sites	Unified records recognize both parents; inclusive protocols; LGBTQ+ training; inclusive signage in safe spaces; feedback mechanisms				
Non-biological parents feel invisible when care is fragmented across sites	Specialist consultant recognizes both parents; continuity through outreach; mental health support for minority stress				
Fear of discrimination leads to 1 in 7 avoiding care	Training addresses homophobia; dashboard monitors sexual orientation outcomes (currently no data); safe reporting mechanisms				

Pregnancy & Maternity (All Women)

Risk	Specific Mitigation	Timescales	Risk Owner	Reporting Committee	RAG
20% of serious incidents directly linked to service isolation when women need care at other sites	Consultant of Day responds to other sites; enhanced on-call; integrated pathways; NWAS coordination; acute specialties available				
Women from most deprived areas (90.5% of gynae transfers, most critical care transfers from poorest 10%) experience worst fragmentation	Outreach to deprived areas; ambulance protocols; dashboard tracks deprivation; accessible safe spaces; mental health integration				
Psychological harm from current service configuration when needing care at multiple sites	Continuity through outreach; safe spaces; integrated mental health; feedback mechanism; staff wellbeing ensures quality				

Intersectionality - Compounded Disadvantage

Risk	Specific Mitigation	Timescales	Risk Owner	Reporting Committee	RAG
Black disabled women face discrimination based on both race and disability	<p>Holistic approach required; dashboard specifically monitors intersectional outcomes; training addresses intersectionality; unified records capture multiple needs.</p> <p>Appropriate use of the Anti-Racism Hub – clinical and non-clinical responding to reports of racial discrimination in patient care and patient outcomes including MNSIs</p>				
Young ethnic minority women with low health literacy in deprived areas face multiple barriers	<p>Specialist outreach; health literacy training; interpreter services; youth-friendly approaches; data monitoring; accessible feedback</p> <p>Anti-Racism Hub – clinical and non-clinical responding to reports of racial</p>				

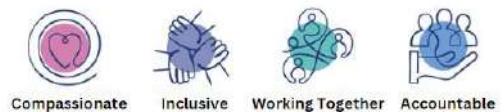
Risk	Specific Mitigation	Timescales	Risk Owner	Reporting Committee	RAG
	<p>discrimination in patient care and patient outcomes including MNSIs</p> <p>Appropriate use of the bilingual volunteers.</p> <p>Consider up skilling bilingual volunteers to provide appropriate support</p>				
Older LGBT+ women from religious minorities navigate multiple forms of potential discrimination	Comprehensive records; inclusive protocols; multi-faceted training; dedicated safe spaces; integrated mental health				

Meeting of the Board of NHS Cheshire and Merseyside

29 January 2026

Lung Cancer Screening: Phase 5 Procurement Recommendations

Agenda Item No: ICB/01/26/10



REPORT SUMMARY SNAPSHOT

Required Information		Details			
Responsible Executive Director		Amanda Ridge, Interim Place Director – Warrington (Senior Responsible Officer for the Lung Cancer Screening Programme)			
Report approval		By	ICB Executive Committee		
		Date	08 January 2026		
Presented by		Jon Hayes, Managing Director, Cheshire and Merseyside Cancer Alliance			
Ask of the Board		Approval	✓	Decision	
		Endorsement		Ratification	
		Receive assurance		Note	
Route to Board – where has this report been discussed		ICB Executive Meeting on 8 January 2026 ICB Finance, Investment and Resource Committee (FIRC) on 22 January 2026			
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 (Health inequalities), P14 (Access and performance recovery), P13 (Financial sustainability)			
Financial Implications		Yes	✓	No	
		If Yes: Approval will allow C&M to access £12.7m national activity-based funding over two years for phase 5 of the lung cancer screening programme.			
		Have the financial implications been reviewed by the Director of Finance			
		Has a budget been identified			
Legal Implications		Permitted contract modification under Provider Selection Regime 2023 / Public Contracts Regulations 2015.			
Conflicts of Interest associated with this report		N/A			
Impact assessments undertaken		Equality	✗		
		Quality	✗		
		Data	✗		
		Sustainability	✗		
Public or Clinical engagement undertaken		Established LCSP on-boarding process will be adapted for Cheshire East and Cheshire West to support awareness and uptake.			

Lung Cancer Screening: Phase 5 Procurement Recommendations

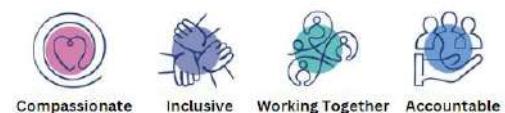
1. Executive Summary

- 1.1 Approval is sought for a permitted modification to the existing Liverpool Heart and Chest Hospital (LHCH) contract (Total 2025/26 contract value of £179.6m) to deliver Phase 5 of the Lung Cancer Screening Programme (LCSP) across Cheshire East and Cheshire West Places. This follows recommendation from Cheshire and Merseyside Cancer Alliance (CMCA), and endorsement from the ICB Executive Committee and ICB Finance, Investment and Resources Committee (FIRC).
- 1.2 The LCSP is already delivering strong outcomes across Cheshire and Merseyside, with over 700 cancers detected—most at an early, treatable stage. Extending the programme to the final two Places is expected to identify more than 520 additional cancers and will ensure equitable access to a Section 7a mandated national service aligned with ICB priorities on early diagnosis, prevention and reducing health inequalities.
- 1.3 Phase 5 will be funded entirely through national activity-based payments (£12.7m over two years), sitting well below the 25% threshold for a permitted contract modification. National funding is confirmed through 2029/30, supporting full rollout by 2030.
- 1.4 Identified risks relate to funding confirmation for 2026/27, agreement of the financial envelope with LHCH and wider pathway considerations (Cardiovascular Disease (CVD) follow-up and spirometry), however robust mitigations are in place. The risk of procurement challenge is low.
- 1.5 Failure to approve would delay implementation of a mandated national programme across the region, risk missing national deadlines, prolong inequity for Cheshire East and Cheshire West residents and delay access to national funding.
- 1.6 Subject to approval, mobilisation will begin in Q4 2025/26 for delivery from Q4 2026/27.

2. Ask of the Board and Recommendations

2.1 The Board is asked to:

- approve the recommendations of CMCA, the Cheshire and Merseyside Integrated Care Board (C&M ICB) Executive Committee and FIRC Committee to allow a permitted modification to the LHCH existing contract for the delivery of Phase 5 LCS services.



3. Background

3.1 The national Lung Cancer Screening Programme (LCSP), mandated by NHSE in 2023, is already delivering strong outcomes across Cheshire and Merseyside, with over 700 cancers detected by December 2025, the majority at early, and treatable stages. Programme data shows:

- 1.4% of eligible participants diagnosed with lung cancer
- 80.3% diagnosed at early stage
- 76.5% treated with curative intent.

Phase 5 will extend these benefits to the final outstanding areas, Cheshire East and Cheshire West, where modelling indicates the programme will detect:

- 520+ cancers,
- 418 at early stage,
- 319 eligible for curative treatment.

3.2 Implementation ensures Cheshire East and Cheshire West residents receive equitable access to a mandated national screening service that is offered in all other Cheshire and Merseyside NHS Places. The LCSP targets communities with high deprivation and smoking prevalence and includes Making Every Contact Count (MECC) interventions and opt-out smoking cessation referrals therefore directly supporting ICB priorities on early diagnosis, prevention and health inequality reduction.

3.4 LHCH delivers LCS for all places in Cheshire and Merseyside where the service is live. LCSP Phases 1 to 4 are included in the main ICB/LHCH contract (total 2025/26 contract value of £179.6m). It is the intention to set up Phase 5 to allow it to ultimately roll into a single ICB-wide contract for a rolling lung cancer screening programme. The estimated value of LCSP Phase 5 is £12.7 million over two years, funded entirely by the national cancer programme through activity-based payments. This value is well below the 25% threshold for a permitted contract modification under the Provider Selection Regime 2023.

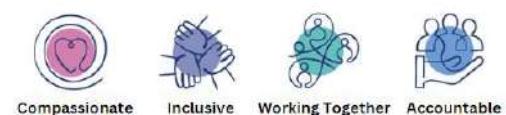
3.5 The paper was discussed at the ICB Executive Meeting held on 8 January 2026 where it was approved for submission to the meeting of the Finance, Investment and Resource Committee (FIRC) held on 22 January 2026. Due to the contract value of £12.7m, final approval is required from the ICB Board.

4. Key Risks

4.1 Funding for Phase 5 in 2026/27 is not fully confirmed until national trajectory reviews in early 2026, though NHSE has secured the overall LCSP budget through to 2029/30 and will prioritise contractually committed activity.

4.2 The financial model presents some risk: if a viable financial envelope cannot be agreed with LHCH, a full procurement may be required, although economies of scale and activity-based funding make this unlikely. A major operational review is underway to build efficiencies and mitigate this risk.

4.3 Wider pathway considerations: LHCH has created a CVD service, funded by the ICB, to review patients newly identified with Coronary Artery Calcification who have no prior CVD diagnosis and are not on cholesterol-lowering therapy. While this service complements the LCSP, it sits outside national LCS protocols, so LCSP expansion is



not dependent on CVD service growth. There is a risk the service may exceed its current funding capacity, potentially shifting workload back to primary care. CMCA, LHCH Leads and the ICB CVD Prevention Team are reviewing the model to maximise capacity within recurrent funding and maintain access for new incidental CAC findings as the LCSP expands. Spirometry capacity is also limited however spirometry remains an optional pathway element, so it should not block programme rollout.

- 4.4 The risk of a procurement challenge from an independent provider is low due to the specification requirement for a fully integrated, end-to-end MDT service.
- 4.5 Failure to approve the recommendation would delay the mandated Section 7A screening rollout, jeopardise achievement of national coverage deadlines, widen existing inequalities in Cheshire East and Cheshire West, delay access to national funding, and undermine public confidence in the regional system.

5. Finance

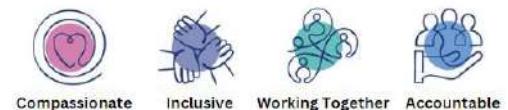
- 5.1 National activity-based funding continues to underpin the LCSP, with Cheshire and Merseyside receiving £8m in 2024/25 and £11.7m for Phases 1–4 in 2025/26, contributing to a total LHCH contract value of £179.6m in 2025/26. Phase 5 is estimated at £12.7m over two years—below the 25% threshold—allowing a direct award to LHCH under existing regulations. National trajectories for 2026/27 are due in January 2026, with final funding confirmation in March; committed activity will be prioritised. NHSE has confirmed LCSP funding through 2029/30, supporting full rollout by 2030.
- 5.2 While national funding excludes smoking cessation and spirometry, local mitigations are in place for example, smoking cessation demand is absorbed by Public Health-commissioned services. Although Phase 5 requires no ICB funding, wider system impacts should be acknowledged, alongside the significant national investment and expected long-term savings from earlier diagnosis and reduced smoking prevalence.

6. Communication and Engagement

- 6.1 Subject to approval, CMCA will commence established onboarding with Places, provider and partners, adapting communications successfully used in earlier phases (community engagement, local events, videos, social media, tailored press) for Cheshire East and Cheshire West.

7. Next Steps and Responsible Person to take forward

- 7.1 CMCA & C&M ICB to confirm decisions with LHCH and commence mobilisation in Q4 2025/26 for delivery from Q4 2026/27.
- 7.2 Responsible Leads
 - Senior Responsible Officer - Amanda Ridge, Interim Place Director Warrington
 - CMCA LCS Programme Team
 - Liam Connolly, Senior Programme Manager
 - Lyndsey Booth, Senior Project Manager
 - ICB Procurement / Contracting Support.



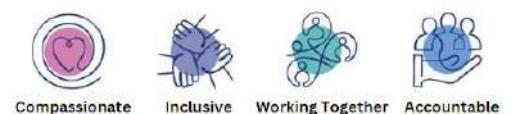
Meeting of the Board of NHS Cheshire and Merseyside

29 January 2026

Report of the Chief Executive

Agenda Item No: ICB/01/26/11

Responsible Director: Liz Bishop
Chief Executive



REPORT SUMMARY SNAPSHOT

Required Information		Details			
Responsible Executive Director		Liz Bishop			
Report approval	By	Liz Bishop			
	Date	21.01.26			
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 P17: Workforce Capacity, Capability, and Morale:			
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 (January 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.

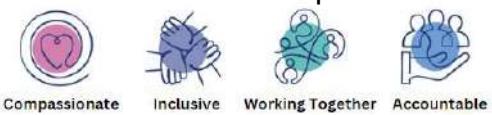
2. Ask of the Board and Recommendations

- 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
 - to formally **ratify** its endorsement of the changes to the Constitution and note the approval of the updated ICB Constitution by NHS England.

3. Key Updates

Executive Team Changes

- 3.1 Director of Nursing and Care, Chris Douglas MBE, and Medical Director, Prof. Rowan Pritchard Jones, have left/are leaving the ICB this month. On behalf of everybody at NHS Cheshire and Merseyside, I would like to say a big thank you to both Chris and Rowan for their leadership, dedication and hard work. Rowan and Chris have made a significant contribution to the organisation and the local health and care system. Both will be missed by their ICB colleagues and I'm sure that you will join me in wishing them well for the future.
- 3.2 Board Members are aware that in early December 2025 the ICB initiated a consultation with individuals who are currently the direct reports to myself regarding proposed changes to the ICB Executive Director Team. Following the close of the consultation, a selection and appointment process was initiated to the new Executive Director Team structure. At the time of writing and publishing this report the following posts have been successfully appointed to:
 - Executive Director of Finance and Contracting – Andrea McGee
 - Executive Director of Health and Integrated Care Commissioning – Clare Watson.
- 3.3 I am sure you will join me in extending congratulations to Andrea and Clare on their appointments. We are in the process of recruiting to the remaining two Executive Director Team posts (Executive Clinical Director and Executive Director of Corporate and Governance), the appointment status of which I hope



to be able to update you on at the January Board meeting, and with the intent that the new Executive Director Team structure commences from 01 February 2026.

3.4 I would also like to welcome Jude Adams, who has joined us as Interim Executive Director of Strategy and Transformation (Turnaround). Jude joins us on secondment from her role as Executive Chief Delivery Officer at Northern Care Alliance NHS Foundation Trust and will strengthen Executive leadership team at a time of system-wide financial recovery.

Changes to the ICB Constitution

3.5 Prior to the end of December 2025, Board members were contacted outside of the formal Board meeting cycle seeking their support to proposed changes to the ICBs Constitution (Appendix One) which are largely based around Board composition and reflect the proposed changes to the Executive Team structure and their inclusion as Board Members. Support was sought, and received, from Board members to enable the timely submission of a Constitution variation request to NHS England so that the request can be considered by the North West NHS England Regional Executive Team ahead of Januarys Board meeting. The ICB received confirmation of NHS England's approval of our proposed Constitutional changes on 22 January 2026 at which point the updated Constitution came into effect. The updated Constitution is published on the ICBs website.

The Board is asked to formally ratify its endorsement of the changes to the Constitution at the January Board meeting and note the approval of the updated ICB Constitution by NHS England.

Voluntary Redundancy Update

3.6 As Board members are aware, following the publication of the Model ICB Blueprint¹ earlier this year, outlining how ICBs must transform to meet major cost reductions and align with the 10-Year Health Plan, the ICB has progressed the Voluntary Redundancy (VR) scheme as part of the wider organisational change. The VR process has generated a significant response from ICBs colleagues and it expected that by the end of January decisions will have been made with regards to the number of staff whose applications have been approved. I hope to be able to update you further on this at the January Board meeting.

Cheshire and Merseyside Health and Care Partnership Update

3.7 Our collective work across Cheshire and Merseyside continues to gain national recognition - most recently through our contribution to the National Child Poverty Strategy and coverage in The Municipal Journal, demonstrating the tangible impact a unified system can deliver through the All Together Fairer programme. Both the Liverpool City Region and Cheshire & Warrington have

¹ <https://www.england.nhs.uk/long-read/update-on-the-draft-model-icb-blueprint-and-progress-on-the-future-nhs-operating-model/>

reaffirmed their commitment to embedding All Together Fairer within the emerging devolution landscape, following their pledges at the National Marmot Conference in Liverpool. As the ICB navigates a period of significant organisational transition, we remain committed to ensuring these principles inform our refreshed strategic approach, including the future development of Neighbourhood Health services.

3.8 In light of recent announcements within the NHS 10-Year Health Plan, the Government has confirmed that it intends for the statutory requirement for Integrated Care Partnerships to exist — and to produce Integrated Care Strategies — will be removed. While local partnerships may continue in some form, this marks a substantive shift in national policy and provides an opportunity to redesign how we organise collaboration across our geography. Against this backdrop, and to ensure the effective use of system resources, partners across the Liverpool City Region and Cheshire & Warrington are working with the ICB to develop two new sub-regional forums as future vehicles for joint working.

3.9 Given these developments, we intend to place the current structure and meeting arrangements of the Cheshire and Merseyside Health and Care Partnership (HCP) into abeyance while the new governance arrangements are co-designed. Although the HCP remains a legal entity until legislative changes are enacted, its operational meetings will pause, and longstanding diary invites will be withdrawn. We will keep Board members updated on progress, including how they can support the next phase of development as these new sub-regional arrangements take shape.

Specialist inpatient palliative care beds – Liverpool

3.10 Over the past months, NHS University Hospitals of Liverpool Group have been working with the ICB with an aim to provide specialist palliative care inpatient beds to support palliative and end of life patients in the south and centre of the city. We are pleased to confirm that a number of specialist palliative care inpatient beds opened at Maple Suite on the Liverpool Heart and Chest Hospital site on Monday 19 January 2026.

3.11 Referrals to the unit will continue to be co-ordinated through the IMPaCT hub as previously. We are grateful for the hard work of all the teams involved.

Cheshire and Merseyside Neighbourhood Health Programme

3.12 NHS Cheshire & Merseyside continues to drive a shared vision of delivering better care, closer to where people live, through Integrated Neighbourhood teams (INTs) and collaborative working. The established governance structure regularly reviews progress of work informed by the national guidelines 2025/26 and, in the absence of the anticipated 'Model Neighbourhood Framework' utilising the draft priority six steps to plan for the 2026/27.

3.13 On 15 January 2025 the national lead, Dr Minal Bakhai, visited the two pioneer sites in Cheshire and Merseyside: Sefton and St Helens. Staff and partners

(including the two Local Authorities, GPs, community and acute providers and the voluntary sector) enjoyed the opportunity to present the work and engage in discussions about the opportunities and challenges facing the organisation in delivering neighbourhood health as we move forward. Both visits received positive feedback, and this is a credit to all involved. The national lead, working with the national and place coaches will continue to share good practice with pioneer sites to help progress local plans and provide valuable insight to wider partners across Cheshire and Merseyside.

- 3.14 Other Places are progressing well and, in some instances, setting good examples of best practice. The next Neighbourhood Health Programme Board is due to take place on 11 February 2026 where we will continue to provide assurance of progress using highlight reports from each place and core component lead.
- 3.15 At its meeting in March 2026, the ICB Board will receive a comprehensive update on progress around the Neighbourhood Health Programme.

Workwell Update

- 3.16 WorkWell is a national early-intervention programme designed to integrate work, health and skills support across all ICB areas in England. It aims to reduce rising economic inactivity driven by long-term sickness by providing personalised, holistic support to anyone of working age with a disability or health condition whose employment is at risk. WorkWell services are built around a biopsychosocial model, delivered primarily through Work and Health Coaches and supported by multi-disciplinary teams. These teams help people stay in work, return from sickness absence or enter employment, connecting them seamlessly to wider health, skills, community and employment services.
- 3.17 From 2026, all ICBs will form WorkWell Partnerships with Local Authorities, Jobcentre Plus and community organisations to design and deliver their local offer. The funding allocation for Cheshire and Merseyside is £1.655m in year 1 rising to £4.286m yr 2 and £4.607m in year 3 this has been allocated using a weighted capitation model that reflects local working-age population size and levels of need. There will be a national support offer, and regionally-based advisors.
- 3.18 All areas must put in place governance, data-sharing agreements, referral routes and a multi-agency delivery model, and contribute to a national evaluation programme. As a result, WorkWell represents a major vehicle for system integration, supporting the NHS's role in reducing inequality, improving health outcomes and enabling more people to benefit from good, sustainable work.
- 3.19 Next steps – we have initiated discussions with our partners as part of the two Cheshire and Merseyside Get Britain Working plans, which Board supported at its September 2025 meeting. In addition, we have reviewed the national WorkWell prospectus alongside our Cheshire and Merseyside Work and Health Strategy and we are planning to expand this work to inform our Workwell

submission which is due on the 13 March 2026. A further update will be provided at the March 2026 Board meeting.

Urgent and Emergency Care – Public Awareness Winter Communications

3.20 NHS Cheshire and Merseyside is continuing its public campaign for winter which commenced in November 2025 and compliments national and regional messaging from NHS England. Our campaign balances preventative and interventional messaging.

3.21 Over the pre-Christmas period, the campaign focussed on vaccinations, preventative measures to avoid hospital admissions, signposting to services (NHS 111, Think Pharmacy, Walk in Centres) as well as targeted messaging for hospital discharge. This has continued in January which also focusses on Mental Health interventions.

3.22 Working closely with system partners and the System Control Centre we have supported specific localities with surge advertising in response to episodes of significant hospital pressures throughout January. We also participated in a BBC North West NHS Day on 22 January 2026, which followed an initial feature in December centred at Whiston Hospital focussing on winter preparedness. The follow up focussed on how winter is going and featured system partners from Mersey & West Lancs (MWL), Merseycare as well as colleagues from Primary Care.

3.23 This participation allows us as a system to be open and transparent about the challenges that winter brings and also raise public awareness on preventative messaging and signposting.

Flu vaccination in Front Line Health Care workers

3.24 At the July 2025 Board meeting, we covered how improving Flu vaccination rates can be a highly effective means of mitigating some of the risks associated with winter pressures. We reviewed the data that showed that whilst improvements have been made in some of the eligible population, uptake of seasonal vaccinations in some groups, including Health Care Workers, has been declining over recent years particularly when compared to pre-Pandemic levels.

3.25 At the Board meeting it was agreed that without concerted systemwide commitment to address this, there would be an increased risk of both poorer health in the population and additional burden placed on the health and social care system this winter. It was also agreed that we wanted to go further than the NHS England ambition for all Providers to achieve uptake of 5% more than last year and instead we set ourselves a local ambition for all Providers to vaccinate at least 50% of their staff during the 25/ 26 campaign.

3.26 Whilst this years campaign doesn't officially come to an end until 31 March 2026, I'm pleased to advise that 14 of our 16 Providers have already achieved a

higher percentage uptake than they did last year and six of them have achieved the local target of 50% or more. Whilst we want to get back to pre-pandemic vaccination rates, we have stopped the previous year on year decline in rate of uptake and this is the first year that we have seen an increase in the percentage of Front Line health care workers being vaccinated since the 2020/21 campaign.

New Years Honours List

- 3.27 I would also like to take this opportunity to congratulate two colleagues on being named in HM The King's New Year Honours List.
- 3.28 ICB Board member Trish Bennett, the Chief Executive of Mersey Care, has been awarded an MBE for services to the NHS, while Dr Graeme Allan, volunteer Medical Director at the Southport Macmillan Centre, has been recognised with a British Empire Medal.
- 3.29 These awards reflect their exceptional commitment to patients and communities and we are incredibly proud to see such shining examples representing our region.

Neurodevelopmental Pathway for Children and Young People

- 3.30 The Cheshire and Merseyside Neurodevelopmental Pathway has made significant progress over the past six months, including the development of a new profiling tool for children and young people, *Knowing Me*. Created by CANDDID in collaboration with stakeholders and families across the region, the tool supports young people to describe how they experience the world, identify their strengths, and outline the support they need across ten key dimensions. Its purpose is to help families, schools, and professionals work together with a shared understanding of what matters most to each young person, ensuring timely access to appropriate support.
- 3.31 Rollout is well underway, with more than 480 professionals from 220 organisations trained since September—including 164 schools—alongside new parent and carer awareness sessions. A public user guide will be available from January 2026, and a digital version of the tool is nearing completion.
- 3.32 Place-based leaders across all nine Places are now working with local authorities to embed the tool within educational settings during 2026, supported by ongoing work to ensure that local services and resources are aligned to the needs identified through the tool.

What Will You Miss Campaign

- 3.33 Cheshire and Merseyside has launched its powerful 'What Will You Miss?' campaign, highlighting the milestone life events smokers could miss out on if they continue to smoke, such as a child's wedding and meeting grandchildren.

3.34 Launched to mark the new year, the campaign calls on smokers to take the first step towards stopping for good, signposting them to how and where they can access support.

3.35 At the heart of the campaign is Shaun's journey - whose story features as our Board story today - who had his first cigarette at just eight years old and, later, went on to develop lung cancer in 2024. Upon his diagnosis, he was introduced to a Tobacco Addiction Specialist Nurse who guided him through the process of quitting, developing a tailored plan that was specific to his motivations and needs.

3.36 Smoking is still the biggest single cause of illness and premature death in Cheshire and Merseyside, with 2 in 3 smokers dying too soon unless they quit.

Blood Pressure Optometry pilot

3.37 Cardiovascular Disease (CVD) is a leading cause of morbidity and mortality in Cheshire and Merseyside. High blood pressure (hypertension) is considered the leading modifiable risk factor for CVD and rarely has noticeable symptoms.

3.38 There are different ways to try and find new hypertensives and this includes opportunistic testing in settings that may capture people that might not go to their GP, such as high street opticians. The ICB has been delivering a pilot in targeted local opticians where blood pressure readings have been taken by trained staff, on consenting patients who are between the ages of 40 – 79 years, who don't have a current hypertension diagnosis and haven't had their blood pressure read in the last 6 months.

3.39 Between June and December 2025, there have been 1243 tests completed across all 9 Places in 60 opticians:

- 11 patients have been referred to urgent care (0.8%)
- 328 patients have been referred to General Practice for routine follow up (26.4%).

3.40 The numbers detected so far are in line with the predicted prevalence of hypertension indicating that this is proving to be an acceptable venue for people to have their blood pressure initially checked.

Cheshire and Merseyside primary care excellence on display at General Practice Awards 2025

3.41 Primary care teams and staff from Cheshire and Merseyside won three categories and were highly commended in another, at a prestigious national awards ceremony. The General Practice Awards are an annual celebration recognising those working in primary care and general practice in the UK. The 2025 awards ceremony was held in London on Friday, 5 December and was attended by finalists from eight GP practices and primary care networks (PCNs) from the region.

3.42 The Sefton Mobile Cervical Screening Partnership, consisting of South Sefton PCN, Southport and Formby PCN, Cheshire and Wirral Partnership NHS Foundation Trust, NHS Cheshire and Merseyside and NHS England North West, received the Clinical Improvement Award for Public Health and Prevention. This innovative pilot used Cheshire and Wirral Partnership's [Living Well Bus](#) to bring cervical screening directly into community settings, removing access barriers and improving uptake among people who were overdue or had never been screened.

3.43 The model has already been replicated across five Places in Cheshire and Merseyside and has been shared nationally as best practice, demonstrating its sustainability and impact on reducing inequalities and preventing avoidable deaths from cervical cancer.

AI Echocardiography

3.44 The Cheshire and Merseyside Physiological Science Network has launched an innovative six-month pilot introducing AI-assisted echocardiography at Whiston Hospital within Mersey & West Lancashire Teaching Hospitals NHS Trust. The new technology is being used alongside traditional echocardiogram processes, with every AI-generated scan reviewed by senior clinicians to ensure patient safety and to compare performance and outcomes with standard practice.

3.45 Early pilot activity has already seen more than ten patients benefit from the new approach. Subject to successful evaluation, this technology has the potential to be rolled out more widely across Cheshire and Merseyside—improving access to vital cardiac diagnostics closer to home and reducing waiting times from referral to test. This work has been made possible through the dedication of the Mersey & West Lancashire team and the clinical leadership of Dr Rajiv Sankaranarayanan, Consultant Cardiologist and Heart Failure Lead for the ICB.

National NHS Staff Survey

3.46 The 2025 staff survey, which ran from September to November 2025, achieved a 58% response rate, with 681 participants out of a total staff cohort of 1,171. Although this is a decrease from the 73% response rate and 852 responses recorded in 2024, engagement remained strong across the organisation. The survey covered a broad range of workforce experience measures, providing a valuable dataset to inform organisational priorities for the year ahead, whilst ensuring the feedback and any actions plan align to the reconfiguration and transition priorities.

3.47 A structured communications and engagement timeline is in place. Our Staff Engagement Forum and People Operations Group will support the action plan and will be involved in discussions with their team Executives. Findings will directly inform team-level action plans and shape organisational priorities for 2026, with assurance reporting scheduled through the People Committee in April 2026. The embargo period for the results will end in March 2026.

Primary school pupils make pledge for healthy lifestyles

3.48 The Oaks Community Primary School in Ellesmere Port has successfully adopted the School's Pledge for a Healthy and Active Future, a framework for primary schools which promotes eating well, being active and overall wellbeing across the school community.

3.49 As part of the School's Pledge, the Oaks Community Primary School has introduced a water or milk-only drinks policy, placed a stronger focus on healthier snacks and packed lunches, and is actively promoting free school meals to ensure all pupils have access to nutritious food. [Watch a video here.](#)

3.50 Pupils also wear an Always Active Uniform so they're ready for activity at any time, while teachers encourage more movement during lessons and playtimes.

3.51 This healthy initiative is an example of the NHS's shift from treating sickness to focusing on prevention; a key ambition of the 10 Year Health Plan for England.

Extra urgent dental appointments now available

3.52 Extra appointments are now available for people in Cheshire and Merseyside who need urgent dental care – including for those who don't have a usual dentist. These appointments are part of the 700,000 extra urgent dental appointments being rolled out across the country, announced by the government in February 2025.

3.53 As part of this commitment, NHS Cheshire and Merseyside was allocated funding for an additional 46,600 urgent appointments - and these appointments are available now at 124 local NHS dental practices, which is around a third of all practices providing NHS dentistry in the region. These urgent dental appointments can support the treatment of a wide range urgent dental conditions. More information on urgent dental conditions covered under this scheme, go to: NHS.uk/urgentdentalcare

3.54 We know how important it is to local people that they can get urgent dental care quickly when they are in pain or need help urgently, so we're pleased to be offering these extra NHS funded urgent dental appointments, and would encourage anyone who needs urgent dental care to take up this offer.

3.55 Although these extra appointments are for urgent dental treatments only, there is also further work underway nationally to help improve dental workforce recruitment, retention and training, and ensure better access to general dental services too.

All Together Smiling

3.56 The Cheshire and Merseyside All Together Smiling programme has distributed more than 325,000 oral health packs, with distribution prioritised for children within the most deprived communities, including Children and Young People with SEND, and other children impacted by health inequalities. Two hundred

and fifty-four childcare settings are undertaking daily supervised toothbrushing with over 11,500 children, this is 46% of all eligible settings.

- 3.57 Five Place areas (Cheshire East, Cheshire West and Chester, Sefton, St Helens, and Warrington) have achieved the evidence-based 50% programme participation target. A communications campaign has been launched to support the recruitment of additional settings. This includes a new setting recruitment pack distributed to non-participating settings, alongside a C&M wide engagement roadshow providing an additional call to action for more settings to take part.
- 3.58 This healthy initiative is another example of the NHS's shift from treating sickness to focusing on prevention; a key ambition of the 10 Year Health Plan for England.

Appropriate Places of Care – go live of Complex Needs Hub

- 3.59 Warrington's Complex Needs Hub 'Aviary House' is the first of several planned 'Appropriate Places of Care' for some of our most vulnerable Children and Young People (CYP) in Cheshire & Merseyside. Aviary House is a joint venture between the ICB, Warrington Borough Council and Merseycare to ensure we can provide timely access to evidence based and intensive support for our most complex children and young people.
- 3.60 This new provision, that went live in May 2025, combines a new four bed facility with a multi-disciplinary team to ensure we can keep our C&YP safe and in our local communities, close to home. Since 'go-live' in May 2025 partners have been working to move to a fully staffed model and have begun accepting CYP into the model of care. As of February 2026 we will be fully staffed and are looking to extend the offer to the neighbouring places of Halton, St Helens & Knowsley. Initial findings show significant improvements in outcomes for CYP and also substantive savings through the model.

4. Decisions taken at the Executive Committee

- 4.1 At its meetings throughout December 2025 and January 2026, the Executive Committee has also considered papers and made decisions within its authority on the following areas:
 - **Lung Cancer Screening Programme** – a paper was considered and supported regarding progression to Phase 5 of the Targeted Lung Health Checks within Cheshire and Merseyside. The programme is now part of the national screening portfolio, with recurrent national funding confirmed and reviewed by finance leads. Due to the scale of expenditure within the proposal it was confirmed and agreed that the proposal will need to proceed through the ICB Finance Committee and on to the ICB Board for final approval.
 - **Area Prescribing Group Recommendations** – a paper was considered providing an update on the activities and decisions of the ICBs Area Prescribing Group (APG). The Committee approved the recommendations of

the APG for new drugs and formulary changes, subject to ongoing monitoring and finance reviews. It was also agreed to receive a bi-annual report which summarised all new drugs approved by the APG, including additional costs and realised savings.

- **NEPTS** – received a report on the planned Non-Emergency Patient Transport Services (NEPTS) tender and endorsed the release of the NEPT tender in January 2026.
- **LIMS** – received a paper and supported the recommendations regarding the Laboratory Information Management System (LIMS) for the collaborative pathology network
- **Oral Nutritional Supplements** – received a paper on and endorsed the acceleration of the Oral Nutritional Supplements Programme across Cheshire and Merseyside.

4.2 Additionally at its meetings throughout December 2025 and January 2026, the Executive Committee has also considered updates discussing the following areas:

- Financial recovery and financial position on a monthly basis
- Marie Curie beds in South Liverpool
- Enforcement Undertakings
- 2026-27 Planning
- AACC
- Capital Allocations
- Financial Governance review
- NHSE Assurance meetings
- Neighbourhood Health
- Flu Vaccination uptake data.

4.3 At each meeting of the Executive Committee, there are standing items in relation to quality and financial matters and Place development where members are briefed on any current issues and actions to undertake. At each meeting of the Executive Team any conflicts of interest stated are noted and recorded within the minutes.

5. Officer contact details for more information

Liz Bishop
Chief Executive

Sally Thorpe, Executive Assistant,
sally.thorpe@cheshireandmerseyside.nhs.uk

6. Appendices

Appendix One: changes to the Cheshire and Merseyside ICB Constitution

Amendments to the NHS Cheshire and Merseyside ICB Constitution

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Version	Reason / nature of revisions	Amendments made	Section & Page
V1.4	Clarity that the Ordinary Members referred to in para 2.1.3 relates to the 3 Ordinary Members stated in the Health and Care Act and known locally as Partner Members	<p>2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as “the Board” and members of the ICB are referred to as “Board Members”) consists of:</p> <ul style="list-style-type: none"> a) a Chair b) a Chief Executive c) at least three Ordinary Members (<i>referred to as Partner Members</i>). 	Chapter 2 – Composition of the Board p10
V1.4	Clarity that the Ordinary Members referred to in 2.1.5 relates to the Ordinary Members stated in NHSE Statutory Guidance and that the portfolios will be covered by the C&M Executive Director roles named in para 2.2.3	<p>2.1.5 NHS England policy requires NHS Cheshire and Merseyside to appoint the following additional Ordinary Members:</p> <ul style="list-style-type: none"> a) three Executive Directors, namely: <ul style="list-style-type: none"> • Director of Finance • Medical Director • Director of Nursing. <p><i>These roles of these Ordinary Members are now covered by the portfolios of the Executive Director roles referenced in paragraph 2.2.3.</i></p>	Chapter 2 – Composition of the Board p10
V1.4	Clarity on the number of roles/positions on the Board	<p>2.1</p> <p>2.2.1 Board of NHS Cheshire and Merseyside membership This ICB has the following Partner Members:</p> <ul style="list-style-type: none"> a) <i>up to 2</i> from section 2.1.6a - providing the ICB with access to a perspective and experience from acute or specialist and mental health care settings b) <i>up to 2</i> from section 2.1. 6b - providing the ICB with access to a perspective and experience from primary care and general practice (as prescribed) c) <i>up to 2</i> from section 2.1. 6c - providing the ICB with access to a perspective and experience from local authorities drawing upon the range of context, circumstance and communities that make up Cheshire and Merseyside. <p>2.2.2 NHS Cheshire and Merseyside has also <i>agreed to appointed</i> the following <i>further additional</i> Ordinary Members to its Board:</p> <ul style="list-style-type: none"> a) three additional <i>up to four</i> Non-Executive Members b) one Ordinary Member (Partner Member) bringing the perspective of the Voluntary, Community, Faith and Social Enterprise (VCFSE) Sector. c) <i>up to four Executive Directors (Ordinary Members)</i>. 	Chapter 2 – Composition of the Board p11

Version	Reason / nature of revisions	Amendments made	Section & Page
V1.4	Confirmation of the total number of roles that make up the voting membership of the Board as well as the name of the roles. Naming all roles is a requirement of NHSE.	<p>2.2.3 The Board of NHS Cheshire and Merseyside is therefore composed of the following members:</p> <ul style="list-style-type: none"> • Chair • Chief Executive • 2 Partner Member(s) NHS Trusts and Foundation Trusts • 2 Partner Member(s) Primary Medical Services • 2 Partner Member(s) Local Authorities • 1 Partner Member Voluntary, Community, Faith and Social Enterprise Sector • up to 6 Non-Executive Members • Executive Director of Finance and Contracting • Executive Clinical Director (encompasses the portfolio of the Medical Director and Director of Nursing) • Executive Director of Health and Care Commissioning • Executive Director of Corporate Services and Governance. • Medical Director • Director of Nursing (known locally as the Director of Nursing and Care). 	Chapter 2 – Composition of the Board p11
V1.4	No requirement to put specifically named roles in for regular participants. Allows greater flexibility for the ICB to reflect changing operating model, partner arrangements.	<p>2.3 Regular participants and observers at the Board meetings of NHS Cheshire and Merseyside</p> <p>2.3.1 The Board of NHS Cheshire and Merseyside may invite specified individuals to be regular participants or observers at its meetings <u>in order to</u> inform its decision-making and the discharge of its functions as it sees fit.</p> <p>2.3.2 Participants will receive advance copies of the notice, agenda and papers for Board meetings. They may be invited to attend any or <u>all</u> of the Board meetings, or part(s) of a meeting by the Chair. Participants will be seated at the Board table at Board meetings along with Board Members. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote.</p> <p>Named and equal participants will include:</p> <ul style="list-style-type: none"> • an individual bringing knowledge of Public Health / Population Health; • an individual bringing knowledge and perspective of Healthwatch; • ICB Executive Team members • ICB Place Directors as required and through rotation • the Chair and/or Co Vice Chair of the Cheshire and Merseyside Health and Care Partnership • the Chair of Health Innovation North West Coast. 	Chapter 2 – Composition of the Board p12

Version	Reason / nature of revisions	Amendments made	Section & Page
V1.4	Confirmation of named ICB Executive Director roles classed as Ordinary Members (voting Members of the Board)	<p>3.9 Medical Director Executive Directors (other than the Chief Executive)</p> <p>3.9.1 These members cover the posts of:</p> <ul style="list-style-type: none"> • Executive Director of Finance and Contracting • Executive Clinical Director • Executive Director of Health and Care Commissioning • Executive Director of Corporate Services and Governance. <p>and individuals must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:</p> <ul style="list-style-type: none"> • be an employee of NHS Cheshire and Merseyside or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act. • be a registered Medical Practitioner. • any other criteria as may be set out in any NHS England guidance. • any other criteria as may be agreed by NHS Cheshire and Merseyside, including: <ul style="list-style-type: none"> • be a member of a recognised professional body. 	Chapter 3 – Appointment Process for Board Members p24
V1.4	Removal of repetition of recruitment process as encapsulated within the process outlined within para 3.9.1	<p>3.10 Director of Nursing and Care</p> <p>3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:</p> <ul style="list-style-type: none"> • be an employee of NHS Cheshire and Merseyside or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act. • be a registered Nurse • any other criteria as may be set out in any NHS England guidance. • any other criteria as may be agreed by NHS Cheshire and Merseyside including: <ul style="list-style-type: none"> • be a member of a recognised professional body. <p>3.10.2 Individuals will not be eligible if:</p> <ul style="list-style-type: none"> • any of the disqualification criteria set out in 3.2 apply. • any locally determined exclusion criteria agreed by NHS Cheshire and Merseyside apply including: <ul style="list-style-type: none"> • compliance with the ICB Board Member Appointments Policy • Any other criteria as may be set out in any NHS England guidance apply. <p>3.10.3 This member will be appointed in line with the process as outlined within the ICBs Board Member Nomination and Appointments Policy. The appointments process will be established by an ICB Board Members Appointments Panel. Membership of a Board Members Appointments Panel should be determined by the ICB Chair and Chief Executive in consultation with the Remuneration Committee but must include at least two Non-Executive Board Members and be supported by a HR professional.</p>	Chapter 3 – Appointment Process for Board Members p25

Version	Reason / nature of revisions	Amendments made	Section & Page
V1.4	Removal of repetition of recruitment process as encapsulated within the process outlined within para 3.9.1	<p>3.11 Director of Finance</p> <p>3.11.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:</p> <ul style="list-style-type: none"> • be an employee of NHS Cheshire and Merseyside or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act • any other criteria as may be set out in any NHS England guidance • any other criteria as may be agreed by NHS Cheshire and Merseyside, including: <p>3.11.1.1 be a member of a recognised professional body</p> <p>3.11.2 Individuals will not be eligible if:</p> <ul style="list-style-type: none"> • any of the disqualification criteria set out in 3.2 apply 	<p>Chapter 3 – Appointment Process for Board Members</p> <p>p25</p>

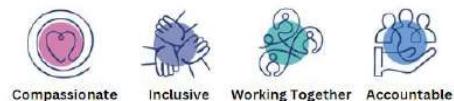
Meeting of the Board of NHS Cheshire and Merseyside

29 January 2026

ICB and System Financial Position – Month 9

Agenda Item No: ICB/01/26/12

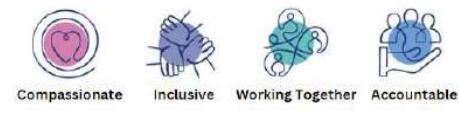
Responsible Director: Andrea McGee, Executive Director of Finance (Interim)



Leading **integration** through collaboration

REPORT SUMMARY SNAPSHOT

Required Information		Details			
Responsible Executive Director		Andrea McGee, Interim Executive Director of Finance and Contracting			
Report approval		By	Andrea McGee		
		Date	21 January 2026		
Presented by		Andrea McGee			
Ask of the Board		Approval		Decision	
		Endorsement		Ratification	
		Receive assurance	✓	Note	✓
Route to Board – where has this report been discussed		Finance, Investment and Our Resources Committee			
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*		P13: Inability to achieve financial sustainability and productivity			
Financial Implications*		Yes	✓	No	
		If Yes:			
		Have the financial implications been reviewed by the Director of Finance			
		Has a budget been identified			
		The report provides an overview of financial performance across the ICB, Providers and Place for information			
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			



ICB and System Financial Position – Month 9

1. Purpose of the Report

1.1 This report provides an update to the Board on the financial performance of the Cheshire and Merseyside ICS (“the ICS”) at Month 9 2025/26, in terms of relative position against its financial plan, and alongside other measures of financial and operational performance (e.g. efficiency, productivity and workforce).

2. Executive Summary

2.1 On 27 March 2025 the System ‘ICS’ plan submitted was a combined £255m deficit, consisting of £23.6m surplus on the commissioning side (ICB) partially offsetting an aggregate NHS Provider deficit position of £278.7m. This plan was not approved by NHS England (NHSE), and subsequently a revised plan of £178.3m deficit (£50.4m surplus for the ICB and £228.6m for providers) was agreed and submitted on 30th April 2025.

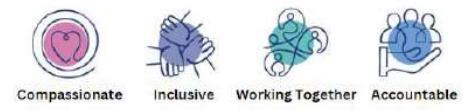
2.2 As part of submitting a £178.3m deficit plan the ICS has been allocated £178.3m deficit support funding from NHSE to cover the deficit and allow the financial system plan to be adjusted to a balanced breakeven position. The funding has been allocated to providers via an agreed system methodology and in turn collective provider plans were improved. Within the original NHS business rules, the revenue deficit support is deemed repayable to NHSE, however an update from NHSE indicates that should the system deliver its 2025/26 plan it will not be repayable. The deficit support funding is released to the system quarterly subject to prospective assurance from NHSE covering areas such as progress with delivery of efficiency plans, and a review of expenditure and workforce run rates.

2.3 The system received £44.5m of deficit support funding (DSF) for Quarter 1 however, due to the level of financial risk in the Cheshire and Merseyside system, the Deficit Support Funding (DSF) for Quarter 2 and Quarter 3 has not been awarded to the ICB. Therefore, the YTD system financial position is adversely affected due to £89m of DSF funding relating to Q2 & Q3 being withheld.

2.4 NHSE has placed several organisations, including the ICB, in formal undertakings, which highlights the level of concern in relation to the forecast position. A recovery plan is required to demonstrate the steps required to move the system into a balanced financial position.

3. Financial Position as at Month 9

- 3.1 As of 31st December 2025 (Month 9), the ICS is reporting a YTD deficit of £173.2m (including Q1 DSF) against a planned YTD deficit of £86.9m resulting in an adverse YTD variance of £86.3m which is all in relation to the withheld DSF.
- 3.2 **Appendix One** contains details of the ICB financial position and the overall system position.
- 3.3 Excluding DSF, the ICS is reporting £3m favourable to plan at month 9, which includes additional funding for Industrial Action costs of £18m, which were not planned for.
- 3.4 It should be noted that the first nine months of the financial year consumes 122% of the annual deficit ICS plan. Significant improvement in the run-rate will be required to meet the plan by the end of the year, i.e. a surplus will need to be delivered in the remaining months.
- 3.5 DSF is being withheld by the region as they want to see a clear and credible plan that describes how the ICS will achieve the improved run-rate and deliver the 2026/27 plan by the end of the year.
- 3.6 The current Mid-case forecast (Appendix 1 slide 5) is a £335m deficit, which is £156m off plan with a best-case forecast of £244m (£66m adverse variance to plan).
- 3.7 The impact on cash positions in NHS Providers is set out in Appendix 1 slide 7. The low levels of cash are impacting on Better Payment Practice Code and resulting in applications to NHSE for distress cash funding (£151m approved so far this year).
- 3.8 NHSE has been working alongside all system partners to work on a consistent underlying position. At Month 9 the underlying position is c£430m, depending on a risk assessment of CIP deliverability. This excludes DSF and assumes that current business rules continue as is. Further work on the underlying financial position will be undertaken as part of the planning process, considering changes to NHS business rules.
- 3.9 Price Waterhouse Coopers (PWC) is continuing to work alongside NHSE and the ICB until the end of the financial year, to undertake monthly reviews with High-risk organisations, including the ICB. In addition, they are conducting Rapid Baseline reviews for high-risk programmes within the ICB and Balance Sheet reviews across all ICS organisations. It is imperative that organisations develop their plans to deliver their control totals at pace, supported by credible delivery actions. These will continue to be reviewed in the ongoing financial performance review meetings.



4. Ask of the Board and Recommendations

4.1 The Board is asked to note the financial position and metrics reported at Month 9 and the risks to delivery of the financial plan.

5. Officer contact details for more information

Andrea McGee

Executive Director of Finance (Interim)

Appendix One: Cheshire and Merseyside ICB/ICS Financial Position Summary Month 9

Appendix 1: Cheshire & Merseyside ICB Financial position headlines

**Cheshire & Merseyside ICS
M9 25/26 – key data
29th January 2026**

Month 9 YTD – C&M ICB Position

ICB Total	C&M ICB TOTAL - Month 9 Position		
	Budget £'m	Actual £'m	Variance £'m
Acute	2,754	2,761	(7)
Community	549	545	5
Mental Health - Contracts	435	448	(13)
Mental Health - Packages of Care	162	163	(1)
CHC	357	358	(2)
Delegated GP	458	455	3
Delegated Other - DOP	243	232	11
Prescribing	410	425	(14)
Primary Care Other	95	94	1
Other Commissioned Services	12	11	1
Other Programmes	45	47	(1)
Reserves	7	0	7
Specialised Commissioning	578	574	5
Sub Total - Programme Expenditure	6,106	6,113	(7)
Running Costs	31	31	0
TOTAL EXPENDITURE	6,136	6,143	(7)
Surplus / (Deficit) Plan	38	0	38
Sub Total - Net Surplus / (Deficit) Reported	6,174	6,143	31

ICB Headlines Month 9

£31m surplus YTD, against a plan of £38m surplus i.e. £7m adverse to plan.

Key overspends continue to be:

- Primary care prescribing (£14m)
- ADHD (£15m)
- Acute Sector (incl. Independent Sector) £7m
- All Age Continuing Care (£2m)

Offset by the following key underspends:

- Delegated POD £13m (includes £6m prior year)
- Community (non-NHS expenditure) £5m
- MH packages of care £1m
- Reserves £6m
- Specialised commissioning £5m

Risks

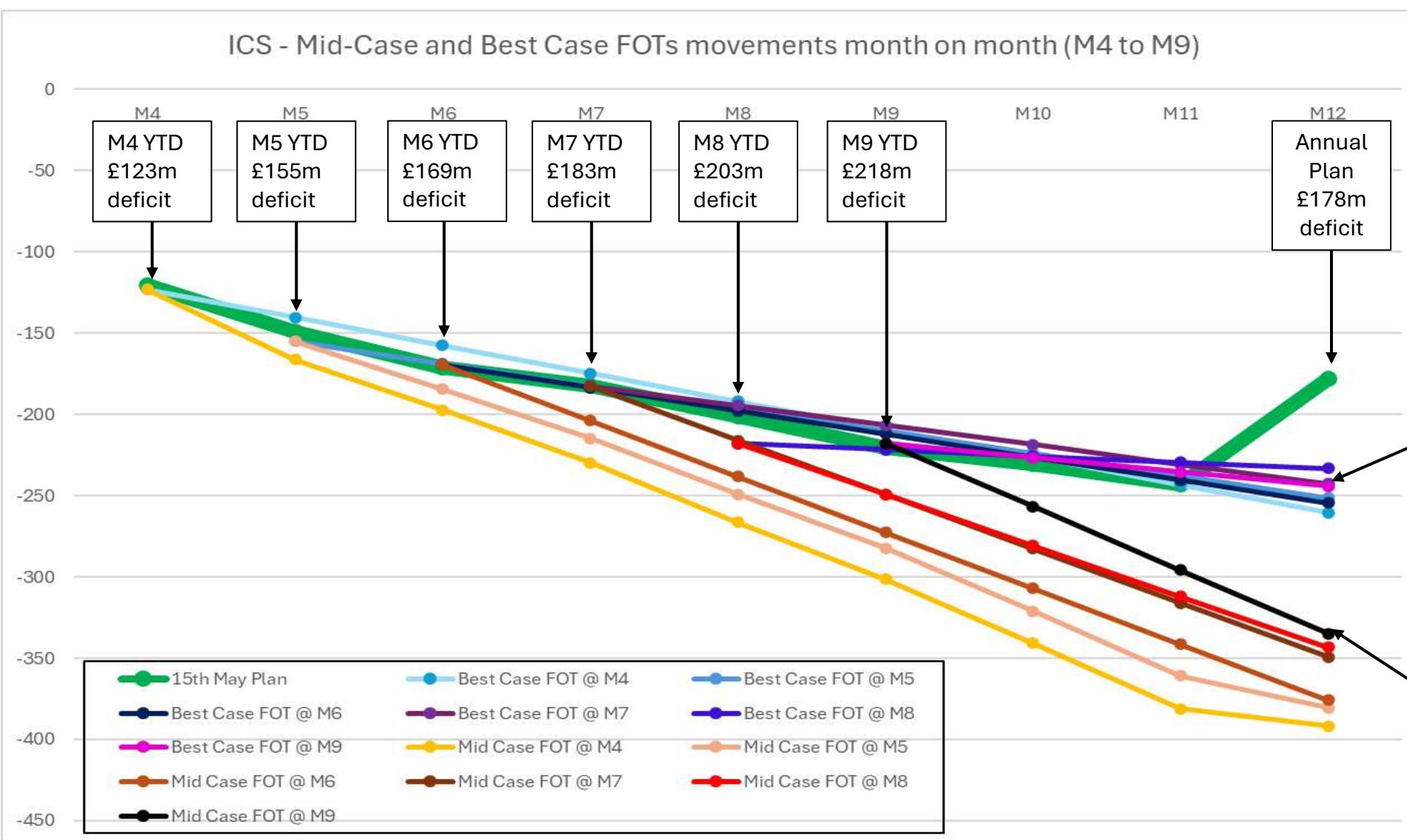
- Delivery of Q4 CRES
- Additional mitigations required to deliver plan

Month 9 – C&M ICS YTD I&E – based on key data

Org	Month 9 YTD (including DSF)			DSF YTD			Month 9 YTD (excluding DSF)			Full Year Plan	M9 YTD as a % of Plan	Mid Case M9 YTD forecast comparison	
	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance			SW M9 YTD Forecast reported in Oct (M7)	M9 YTD actual variance to SW For (mid case)
	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	%	£,000	£,000
Alder Hey Children's	(126)	85	211	0	0	0	(126)	85	211	7,160	1%	225	(140)
Bridgewater Community	(3,161)	(3,157)	4	0	0	0	(3,161)	(3,157)	4	(1,530)	206%	(3,319)	162
Cheshire & Wirral Partnership	(2,654)	(476)	2,178	0	0	0	(2,654)	(476)	2,178	3,985	-12%	(852)	376
Countess of Chester Hospitals	(14,923)	(24,714)	(9,791)	(14,721)	(4,907)	(9,814)	(29,644)	(29,621)	23	(34,042)	87%	(28,533)	(1,088)
East Cheshire Trust	(9,802)	(14,812)	(5,010)	(7,749)	(2,583)	(5,166)	(17,551)	(17,395)	156	(17,934)	97%	(18,225)	830
Liverpool Heart & Chest	6,372	6,372	0	0	0	0	6,372	6,372	0	9,552	67%	6,691	(319)
Liverpool University Hospitals	(31,338)	(53,586)	(22,248)	(33,370)	(11,122)	(22,248)	(64,708)	(64,708)	(0)	(56,609)	114%	(66,233)	1,525
Liverpool Women's	(12,432)	(19,639)	(7,207)	(11,480)	(3,828)	(7,652)	(23,912)	(23,467)	445	(31,024)	76%	(23,692)	225
Mersey Care	4,173	7,527	3,354	0	0	0	4,173	7,527	3,354	14,305	53%	6,170	1,357
Mid Cheshire Hospitals	(15,156)	(26,653)	(11,497)	(17,281)	(5,761)	(11,520)	(32,437)	(32,414)	23	(39,380)	82%	(32,727)	313
Mersey & West Lancs	(29,379)	(36,882)	(7,503)	(22,670)	(7,556)	(15,114)	(52,049)	(44,438)	7,611	(40,950)	109%	(46,658)	2,220
The Clatterbridge Centre	204	216	12	0	0	0	204	216	12	890	24%	211	5
The Walton Centre	5,015	5,104	89	0	0	0	5,015	5,104	89	6,900	74%	5,251	(147)
Warrington & Halton Hospitals	(17,380)	(26,972)	(9,592)	(13,743)	(4,582)	(9,161)	(31,123)	(31,554)	(431)	(28,726)	110%	(32,403)	849
Wirral Community	(200)	1,595	1,795	0	0	0	(200)	1,595	1,795	900	177%	946	649
Wirral University Hospitals	(3,889)	(17,881)	(13,992)	(12,681)	(4,227)	(8,454)	(16,570)	(22,108)	(5,538)	(22,140)	100%	(26,262)	4,154
TOTAL Providers	(124,676)	(203,873)	(79,197)	(133,695)	(44,566)	(89,129)	(258,371)	(248,439)	9,932	(228,643)	109%	(259,410)	10,971
C&MICB	37,775	30,642	(7,133)	0	0	0	37,775	30,642	(7,133)	50,367	61%	28,158	2,484
TOTAL ICS System	(86,901)	(173,231)	(86,330)	(133,695)	(44,566)	(89,129)	(220,596)	(217,797)	2,799	(178,276)	122%	(231,252)	13,455

- Aggregate ICS Position £173.2m deficit YTD (including Q1 deficit support) – £86.3m adverse from plan, of which £89.1m relates to withhold of M4-9 deficit funding support
- Aggregate ICS position £217.8m deficit YTD (excluding deficit support) – £2.8m favourable to plan, the position includes receipt of £18m industrial action funding received in M9.
- The first 9 months of the financial year consumes 122% of the annual deficit ICS plan – effectively meaning a £13m surplus for every month for remainder of the year to achieve plan.

Month 8 – C&M ICS Forecast Risk Range – movements month 4 to month 9



The chart shows the aggregated provider and ICB forecast trajectories and how they have moved over the last 6 months

M9 Best-Case FOT of £244m deficit, improved by £27m between M4 to M8 – but remains £55m adverse to plan

M9 Mid-Case FOT of £335m deficit, improved by £57m between M4 to M9 – but remains £156m adverse to plan

If the average level of underlying improvement continues the system would end up £113m off plan

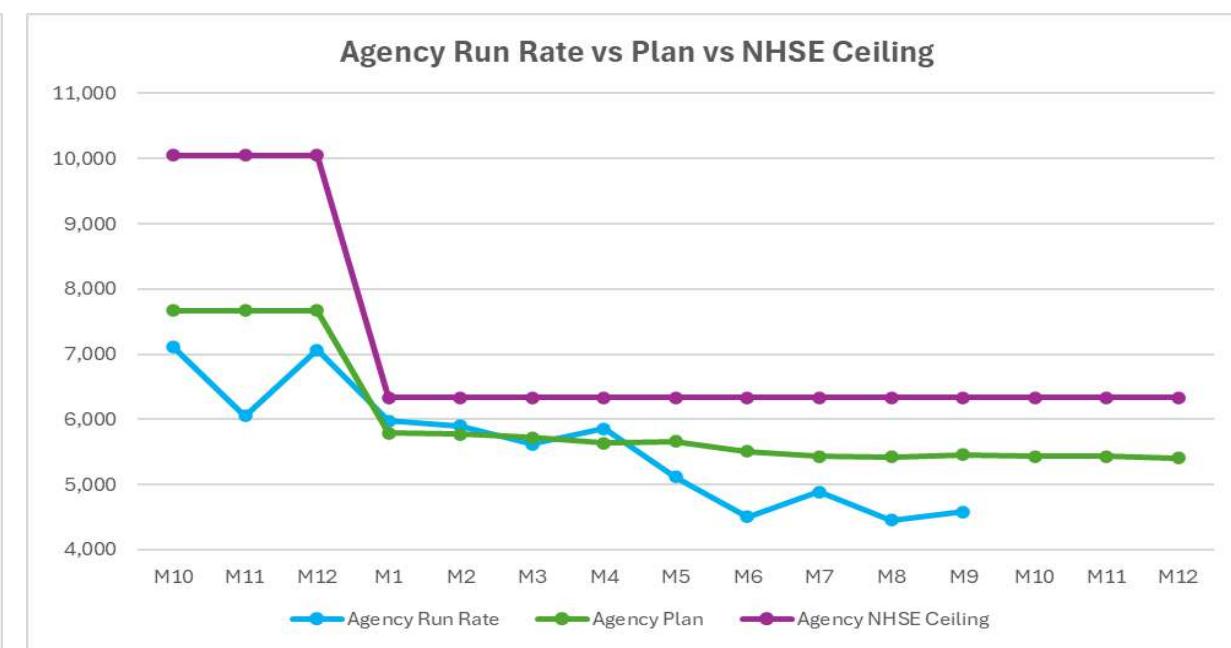
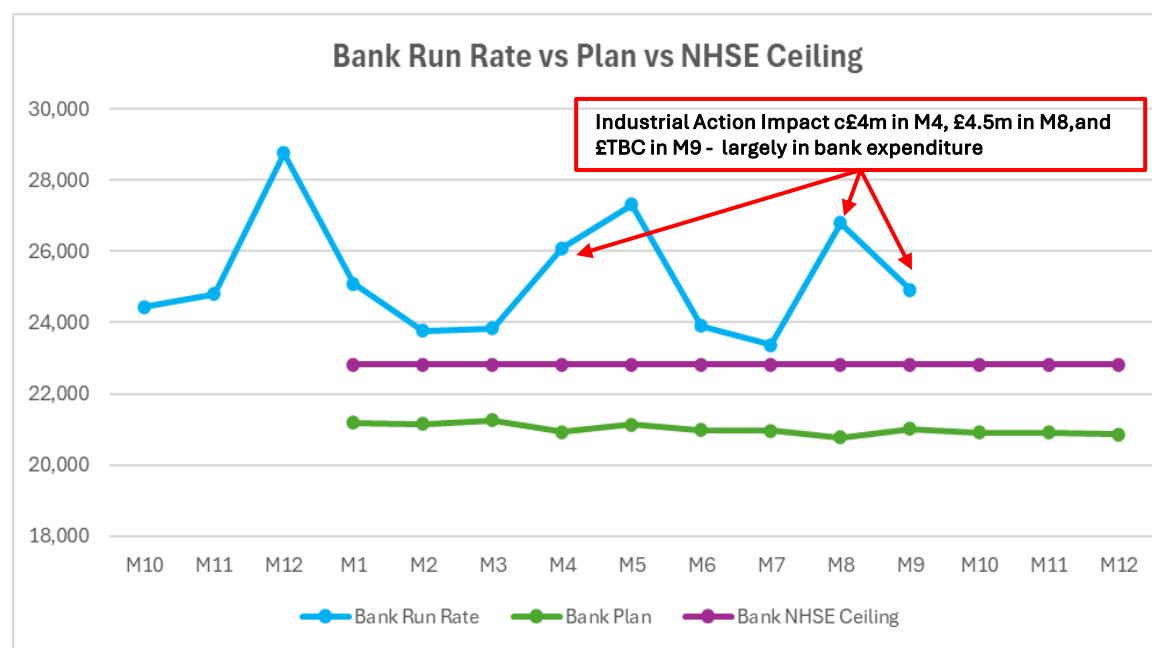
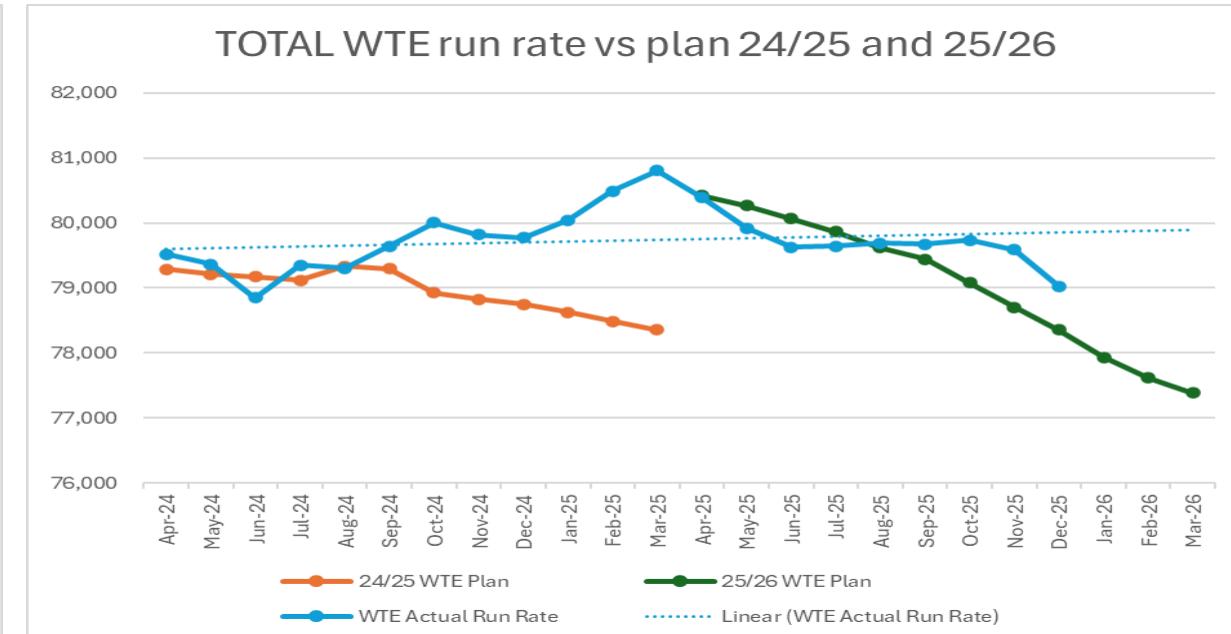
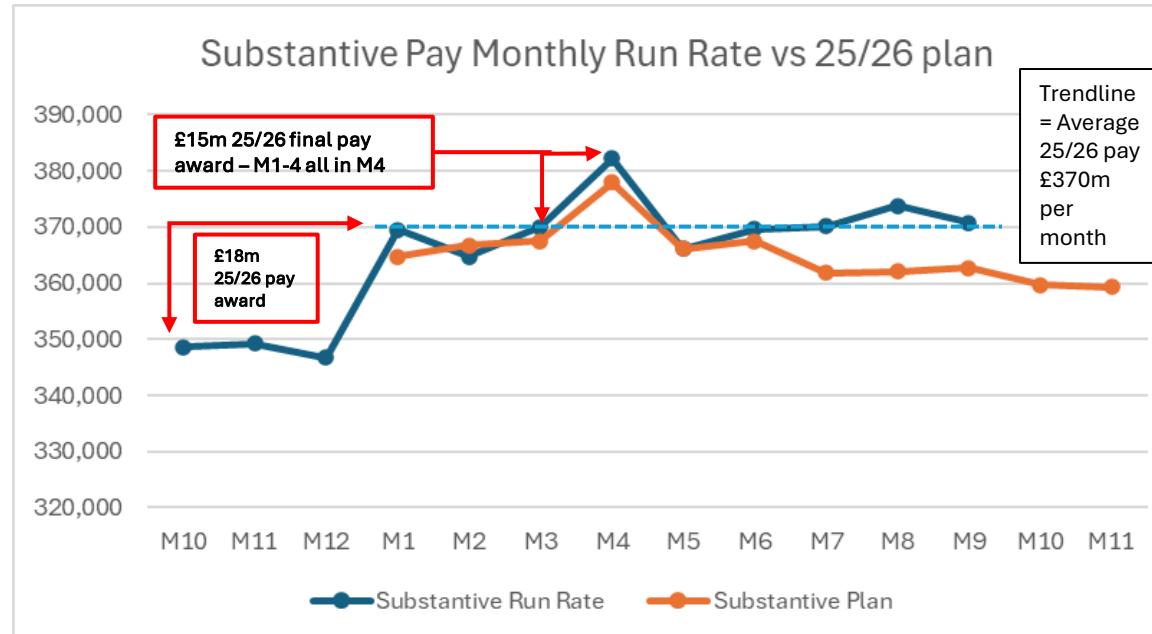
Month 8 – C&M Forecast Risk Range at M9

Organisation	Plan £m	Forecast at M8		Forecast Variance M8		Forecast at M9		Forecast Variance M9		Movement M7 to M8	
		Mid Case FOT £m	Best Case FOT £m	Mid Case £m	Best Case £m	Mid Case FOT £m	Best Case FOT £m	Mid Case £m	Best Case £m	Mid Case £m	Best Case £m
Wirral Teaching	(22.1)	(35.1)	(22.1)	(13.0)	0.0	(35.2)	(23.7)	(13.0)	(1.6)	(0.0)	(1.6)
Mersey & W Lancs	(41.0)	(48.8)	(40.8)	(7.8)	0.2	(45.9)	(38.7)	(4.9)	2.2	2.9	2.1
Liverpool Heart & Chest	9.6	9.6	10.2	(0.0)	0.6	9.6	9.8	0.0	0.2	0.0	(0.4)
Alder Hey	7.2	5.0	7.2	(2.2)	0.0	5.0	7.2	(2.2)	0.0	0.0	(0.0)
Mid Cheshire	(39.4)	(42.4)	(38.3)	(3.1)	1.0	(39.4)	(38.9)	(0.0)	0.5	3.0	(0.6)
LUHFT	(56.6)	(77.7)	(56.6)	(21.1)	(0.0)	(76.2)	(56.6)	(19.6)	0.0	1.5	0.0
Clatterbridge	0.9	0.6	0.9	(0.3)	0.0	0.9	1.0	0.0	0.1	0.3	0.1
Liverpool Women's	(31.0)	(31.0)	(30.8)	(0.0)	0.3	(31.0)	(30.9)	(0.0)	0.2	(0.0)	(0.1)
Walton Centre	6.9	6.8	6.8	(0.1)	(0.1)	7.0	7.0	0.1	0.1	0.2	0.2
East Cheshire	(17.9)	(23.3)	(22.8)	(5.4)	(4.9)	(22.3)	(21.9)	(4.4)	(3.9)	1.0	1.0
Countess of Chester	(34.0)	(33.8)	(33.8)	0.2	0.2	(33.8)	(33.8)	0.2	0.2	(0.0)	(0.0)
Mersey Care	14.3	11.4	11.9	(2.9)	(2.4)	12.1	12.6	(2.2)	(1.7)	0.7	0.7
Warrington & Halton	(28.7)	(42.2)	(40.7)	(13.5)	(12.0)	(41.6)	(40.7)	(12.9)	(12.0)	0.6	0.0
CWP	4.0	3.5	4.0	(0.5)	0.0	4.0	4.0	(0.0)	(0.0)	0.5	(0.0)
Bridgewater	(1.5)	(4.4)	(4.4)	(2.9)	(2.9)	(4.4)	(4.4)	(2.9)	(2.9)	(0.0)	(0.0)
Wirral Community	0.9	1.5	1.5	0.6	0.6	2.5	2.5	1.6	1.6	1.0	1.0
TOTAL Providers	(228.6)	(300.4)	(247.9)	(71.8)	(19.2)	(288.8)	(245.6)	(60.2)	(17.0)	11.6	2.2
ICB	50.4	14.8	50.4	(35.6)	0.0	14.7	40.2	(35.7)	(10.2)	(0.1)	(10.2)
TOTAL Providers + ICB	(178.2)	(285.6)	(197.5)	(107.4)	(19.2)	(274.1)	(205.4)	(95.9)	(27.2)	11.5	(8.0)
<u>Other risk adjustments</u>											
ICS 24/25 25/26 system income risk	0.0	(35.8)	(35.8)	(35.8)	(35.8)	(38.6)	(38.6)	(38.6)	(38.6)	(2.8)	(2.8)
LUFT Legal Case	0.0	(22.0)	0.0	(22.0)	0.0	(22.0)	0.0	(22.0)	0.0	0.0	0.0
TOTAL C&M ICS	(178.2)	(343.4)	(233.3)	(165.2)	(55.0)	(334.7)	(244.0)	(156.5)	(65.8)	8.8	(10.8)

- **Best Case FOT** = assumes all currently identified CIP and mitigations plans delivery in full
- **Mid Case FOT** = this is the most likely case based on current plans taking into account delivery risk

- Mid Case FOT @ M9 is £334.7m – improved by £8.7m compared to M8 but £156.5m adverse to plan. Driven by £18m of industrial action funding offset by Dec IA costs c£6m not in M8 FOTs, c£2.6m income misalignment, and £0.1m change in ICB FOT.
- Best Case FOT @ M9 is £244.0m – deterioration of £10.7m compared to M8, £65.8m adverse to plan – largely driven by changes at WUFT and ICB best case FOTs.
- * Other ICS risk adjustments £60.6m @ M9 includes; ERF Income Risk various providers, 24/25 depreciation clawback, ERF 24/25 true up and the LUFT legal claim.

2025/26 Month 9 – pay run rates and WTE run rates at system level



2025/26 Cash – Provider Distressed Cash Requested & Approved YTD

	M1		M6		M7		M8		M9		M10		M11		M12		TOTAL 25/26	
	April		September		October		November		December		January		February		March		Request Approved	
	Request	Approved	Request	Approved	Request	Approved	Request	Approved	Request	Approved	Request	Approved	Request	Approved	Request	Approved	Request	Approved
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Countess of Chester			12.0	1.3	9.0	6.8	3.7	3.7					7.0	TBC			31.7	11.8
Liverpool Womens			3.8	3.8	2.5	2.5			3.0	3.0	2.5	2.5	7.0	TBC			18.8	11.8
MWL			11.0	10.7	11.0	11.0	8.0	0.0	17.9	0.0							47.9	21.7
Warrington & Halton			4.6	4.6	4.0	4.0	2.4	2.4	4.9	4.9	6.9	3.3	1.3	TBC			24.1	19.2
WUTH	14.0	8.0	16.5	10.0	5.5	5.5	6.0	6.0	6.5	6.5	4.0	4.0	2.0	TBC			54.5	40.0
East Cheshire													4.7	TBC			4.7	0.0
LUHFT					21.0	13.8			15.0	8.4	28.1	23.8	13.6	TBC			77.7	46.0
TOTAL	14.0	8.0	47.9	30.4	52.9	43.6	20.1	12.1	47.3	22.8	41.5	33.6	35.7	0.0	0.0	0.0	259.4	150.5

- Table above sets out the YTD distressed cash requests that have been approved by NHSE YTD
- Of the £259.4m requested - £150.5m has been approved, with the cash request for February of £35.7m still under consideration
- The table to the right sets out the DSF funding currently on hold, which is material driver of the request for cash as part of providers underlying deficit positions.
- The impact and downward trajectory on Better Payments Practice Code (BPPC) is shown on the next slide
- System Cash Preservation MoU agreed in year remains in place.

	DSF Loss			
	Q2	Q3	Q4	TOTAL
	£m	£m	£m	£m
	Countess of Chester	4.9	4.9	4.9
Liverpool Womens	3.8	3.8	3.8	11.4
MWL	5.8	5.8	5.8	17.4
Warrington & Halton	4.6	4.6	4.6	13.8
WUTH	4.2	4.2	4.2	12.6
East Cheshire	2.6	2.6	2.6	7.7
LUHFT	11.1	11.1	11.1	33.4
TOTAL	37.0	37.0	37.0	111.0

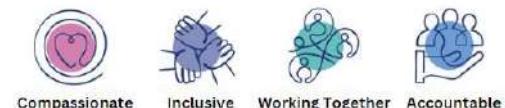
Meeting of the Board of NHS Cheshire and Merseyside

29 January 2026

Highlight report of the Chair of the Finance, Investment, and Resources Committee

Agenda Item No: ICB/01/26/13

Committee Chair: Sue Lorimer, Non-Executive Member



Highlight report of the Chair of the Finance, Investment, and Resources (FIRC) Committee

Committee Chair	Sue Lorimer
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	16 December 2025

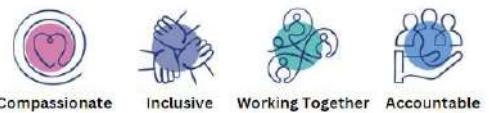
Key escalation and discussion points from the Committee meeting

Alert

- Plan submission approved on behalf of the board of the draft 2026/2028 plan. A financial breakeven position is planned for both years after the recurrent distribution to deficit providers of the ICB's 2025/26 planned surplus of £50m. The 26/27 plan includes a CRES assumption of £75m, £15m of which remains unidentified at this stage. The development of ICB commissioning intentions, and alignment with NHS providers are critical to the completion of the ICB's final plan submission (due for submission 12th February 2026).
- System control totals are no longer applicable, so providers are required to submit their plans individually to NHSE.
- The total 'cost of commissioning' saving of £26m has been taken from the ICB's financial allocation for 2026/27 and 2027/28.
- 16 statements of assurance were required in support of the plan submission. Of these 13 were rated as "developing", 1 was rated as "maturing" and 2 were rated as "not embedded, no assurance". These 2 statements relate to the robustness and phasing of the plan and triangulation across finance, workforce and performance. They will be further developed as a matter of urgency pending the next submission on 12/2/26.
- The committee noted the financial performance of the ICB and ICS at month 8, as follows:
 - ICB reported £1m adverse to plan at month 8 (actual £33m surplus, against planned surplus of £34m). Key risks to delivery were highlighted as savings from the Independent Sector and Primary Care Prescribing.
 - ICS reported £2.4m adverse to plan at month 8 (actual £203.5m deficit, against planned deficit of £201.1m). This includes the loss of Deficit Support Funding (DSF) of £74m, which is significantly increasing the level of cash distress on providers.

Advise

- Financial performance continues to be better than the medium-term forecast. The actual variance to month 8 is £9m better than the forecast, largely due to ICB performance. Provider reps were concerned that the forecast is too pessimistic and might be impacting on the potential to achieve Deficit Support Funding.



- Concern was raised regarding the impact of provider deficits on the availability of funding for other important areas such as Health Inequalities.
- A presentation was received from PWC on their work on financial recovery. They fed back on their work on grip and control and informed the Committee that confusion regarding ownership of the “stretch” savings target had been a contributory factor in slowing down speed of improvement.
- Given the current level of financial risk, loss of DSF, and cash distress. The PWC support to Cheshire & Merseyside ICS will continue in quarter 4.
- A contract update was noted. This included a report on the number of provider accreditation requests being managed, which stood at 117 in December 2025, 47 of which relate to providing Adult ADHD services.
- The Committee approved a request to recommence a tender exercise for Non-Emergency Patient Transport.

Assure

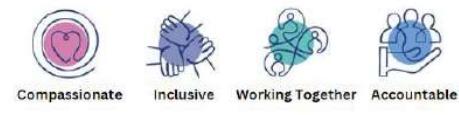
- The committee noted a report on the implementation of, and risk associated with, a new accounting system (Integrated System Financial Environment (ISFE2)). The level of risk has reduced, and further assurance will be sought through a post implementation review by Mersey Internal Audit Agency (MIAA).

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
General risk	Despite no specific risk papers were presented to this meeting. However, a comprehensive discussion took place regarding the risks relating to the 25/26 financial outlook, and the 26/28 draft planning submission.

Board Assurance Framework Risks	
Risk Title	Key actions/discussion undertaken
General risk	Despite no specific risk papers were presented to this meeting. However, a comprehensive discussion took place regarding the risks relating to the 25/26 financial outlook, and the 26/28 draft planning submission.

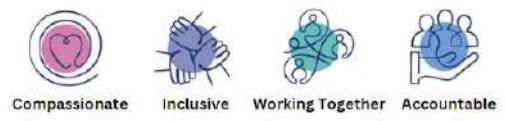


Meeting of the Board of NHS Cheshire and Merseyside

29 January 2026

Integrated Performance Report

Agenda Item No: ICB/01/26/15



REPORT SUMMARY SNAPSHOT

Required Information		Details			
Responsible Executive Director		Jude Adams			
Report approval	By	Anthony Middleton: Director of Performance and Planning			
	Date	22 January 2026			
Presented by		Jude Adams, Interim Executive Director of Strategy and Transformation (Turnaround)			
Ask of the Board	Approval		Decision		
	Endorsement		Ratification		
	Receive assurance	✓	Note		✓
Route to Board – where has this report been discussed		Quality & Performance Committee			
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 P17: Workforce Capacity, Capability, and Morale:			
Financial Implications*	Yes		No		n/a
	If Yes:				
	Have the financial implications been reviewed by the Director of Finance				n/a
	Has a budget been identified				n/a
	The report provides an overview of financial performance across the ICB, Providers and Place for information				
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			

Integrated Performance Report

1. Executive Summary

- 1.1 The integrated performance report for January 2026, see Appendix one, provides an overview of key metrics drawn from the 2025/26 Operational plans, specifically covering Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance. It informs the Board of the current position of key system, provider and place level metrics against the ICB's Annual Operational Plan.
- 1.2 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. Ask of the Board and Recommendations

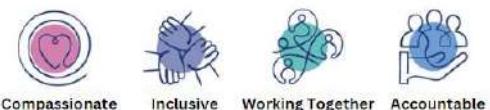
- 2.1 The Board is asked to note the contents of the report and take assurance on the actions contained.

3. Background

- 3.1 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.

4. Risks

- 4.1 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.
- 4.2 There is a risk that the system will not meet elective care recovery targets set out in the 2025/26 Operational Planning Guidance, including referral to treatment times, time to first appointment and 52-week RTT waiting time standards, due to constrained elective capacity, rising demand, workforce shortages and financial constraints. This may result in prolonged patient waits, increased clinical risk, poor patient experience, financial impact, and reputational harm. This corresponds to Board Assurance Framework Risk P14.
- 4.3 Additionally, there is a risk that the system will be unable to deliver timely and effective urgent and emergency care services due to rising demand, workforce



pressures, capacity constraints, and delayed patient discharges. This may result in non-compliance with key NHS 2025/26 planning guidance standards, including the 4-hour ED target, 12-hour decision-to-admit (DTA) breaches, and ambulance handover delays. These risks may contribute to patient harm, regulatory scrutiny, and reputational damage. This maps to Board Assurance Framework Risk P15.

5. Finance

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

6. Next Steps and Responsible Person to take forward

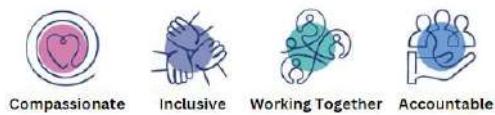
6.1 Actions and feedback will be taken by Anthony Middleton, Director of Performance and Planning. Actions will be shared with, and followed up by, relevant teams. Feedback will support future reporting to the Q&P committee.

7. Officer contact details for more information

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

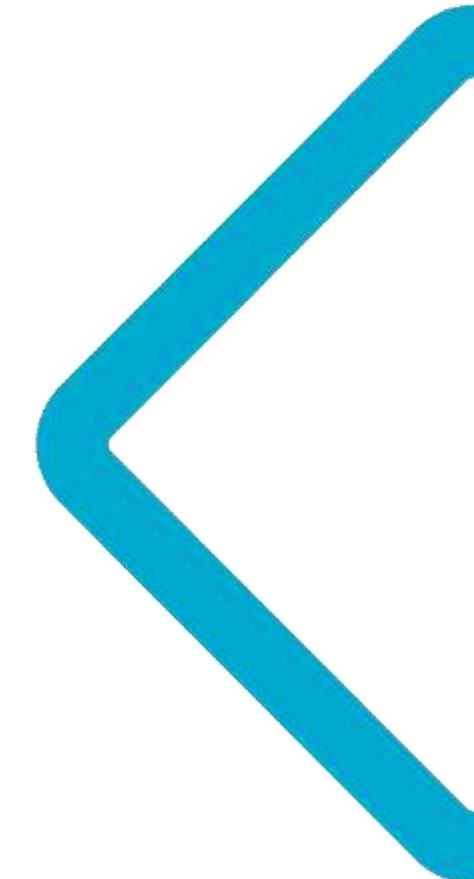
8. Appendices

Appendix One: Integrated Quality and Performance report



Integrated Performance Report

29th January 2026



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Integrated Quality & Performance Report – Guidance	Page 3-5
Section 1: ICB Aggregate Position	Page 6-8
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Section 3: Provider / Trust Aggregate Position	Page 10-12
Section 4: Place Aggregate Position	Page 13-15
Section 5: Exception Report	Page 16-40

Integrated Quality & Performance Report – Guidance:

Provider Acronyms:

ACUTE TRUSTS

COCH COUNTESS OF CHESTER HOSPITAL NHS FT

ECT EAST CHESHIRE NHS TRUST

MCHT MID CHESHIRE HOSPITALS NHS FT

LUFT LIVERPOOL UNIVERSITY HOSPITALS NHS FT

MWL MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST

WHH WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT

WUTH WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT

SPECIALIST TRUSTS

AHCH ALDER HEY CHILDREN'S HOSPITAL NHS FT

LHCH LIVERPOOL HEART AND CHEST HOSPITAL NHS FT

LWH LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

TCCC THE CLATTERBRIDGE CANCER CENTRE NHS FT

TWC THE WALTON CENTRE NHS FT

COMMUNITY AND MENTAL HEALTH TRUSTS

BCHC BRIDGEWATER COMMUNITY HEALTHCARE NHS FT

WCHC WIRRAL COMMUNITY HEALTH AND CARE NHS FT

MCFT MERSEY CARE NHS FT

CWP CHESHIRE AND WIRRAL PARTNERSHIP NHS FT

KEY SYSTEM PARTNERS

NWAS NORTH WEST AMBULANCE SERVICE NHS TRUST

CMCA CHESHIRE AND MERSEYSIDE CANCER ALLIANCE

OTHER

OOA OUT OF AREA AND OTHER PROVIDERS

Key:

Data formatting

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

C&M National Ranking against the 42 ICBs

	C&M in top quartile nationally
	C&M in interquartile range nationally
	C&M in bottom quartile nationally
	Ranking not appropriate/applied nationally

C&M National Ranking against the 22 Cancer Alliances

	C&M in top quartile nationally
	C&M in interquartile range nationally
	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**.

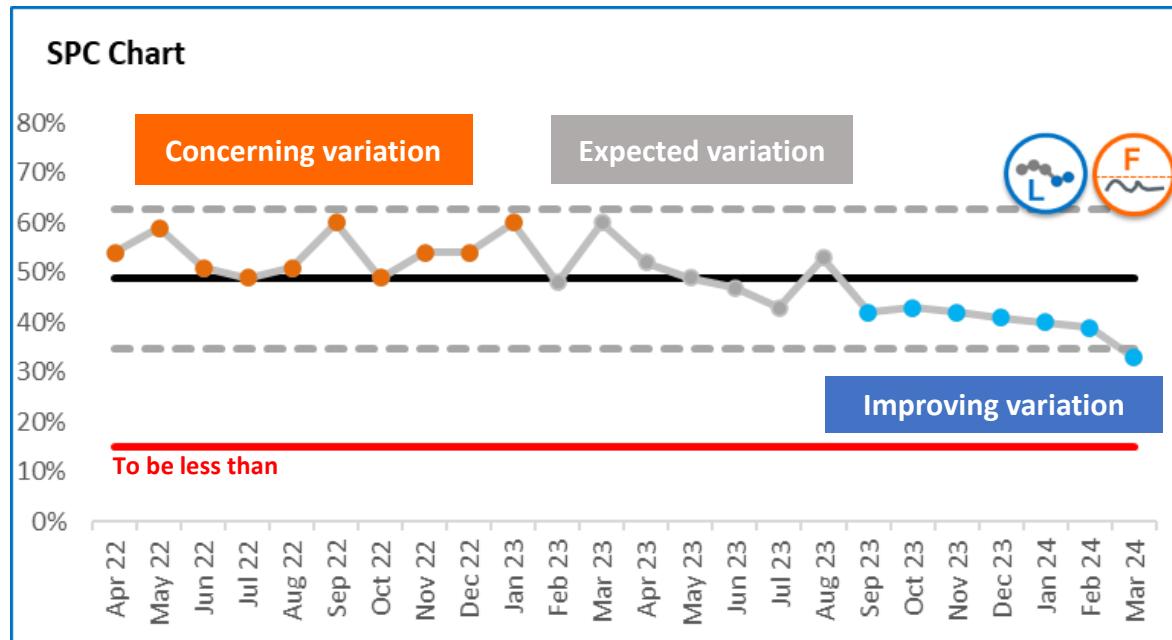
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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



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:

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

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

1. ICB Aggregate Position

Category	Metric	Latest period	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Local Trajectory	National Target	Region value	National value	Latest Rank
Urgent care	4-hour A&E waiting time (% waiting less than 4 hours)	Dec-25	71.4%	72.9%	73.1%	72.6%	72.7%	73.7%	73.0%	71.9%	72.8%	72.5%	71.9%	72.4%	71.5%	76.5%	78% by Year end	71.5%	73.8%	28/42
	Ambulance category 2 mean response time	Dec-25	01:06:45	00:52:51	00:38:28	00:32:43	00:27:58	00:26:44	00:30:22	00:32:05	00:27:24	00:28:44	00:32:51	00:37:31	00:45:25	-	00:30:00	00:34:29	00:33:01	41/42
	Mean Ambulance Handover time (ED and Non ED)	Dec-25	00:55:51	00:47:53	00:39:09	00:34:32	00:34:23	00:31:57	00:32:58	00:31:04	00:25:02	00:27:41	00:31:48	00:34:37	00:38:39	00:33:46	00:15:00	00:30:07	00:30:28	32/42
	A&E 12 hour waits from arrival (Type 1 & 2)	Dec-25	18.3%	18.3%	17.4%	16.2%	15.9%	16.6%	16.8%	17.0%	16.3%	17.6%	17.2%	17.1%	17.4%	16.5%	-	14.2%	10.5%	41/42
	Adult G&A bed occupancy (all acutes)	Dec-25	96.0%	97.4%	97.2%	95.9%	96.4%	96.5%	95.8%	95.6%	94.9%	96.1%	95.7%	96.2%	94.3%	94.9%*	92.0%	93.7%	93.4%	23/42
	Percentage of beds occupied by patients no longer meeting the criteria to reside (Rolling 7-day average last week of month)	Dec-25	19.5%	22.7%	21.6%	22.9%	21.2%	20.0%	20.3%	20.0%	20.7%	19.7%	19.1%	19.7%	18.7%	17.7%	-	n/a	n/a	-
	Discharges - Average delay (exclude zero delay)	Nov-25	8.8	9.5	9.0	10.1	9.8	8.8	8.6	8.4	7.9	8.6	8.8	8.2		8.8		7.0	5.9	36/42
Planned care	Percentage of patients discharged on discharge ready date	Nov-25	89.1%	88.2%	89.0%	89.0%	88.3%	88.3%	88.4%	88.5%	88.5%	89.1%	87.2%	85.9%		84.7%		85.8%	84.7%	18/42
	Total incomplete Referral to Treatment (RTT) pathways	Nov-25	361,746	358,637	356,570	360,184	354,386	350,979	355,722	362,412	366,066	367,700	367,494	355,626		346,113	-	1,017,481	7,159,010	-
	The % of people waiting less than 18 weeks on the waiting list (RTT)	Nov-25	56.7%	56.5%	57.3%	58.0%	58.0%	59.1%	59.0%	58.7%	58.4%	59.2%	59.4%	59.1%		60.9%	92.0%	59.0%	61.6%	35/42
	The % of people waiting more than 52 weeks on the waiting list (RTT)	Nov-25	3.3%	3.4%	3.3%	3.0%	3.5%	3.7%	3.9%	3.9%	3.9%	3.6%	3.3%	2.9%		2.1%		2.2%	2.3%	38/42
	Number of 52+ week RTT waits, of which children under 18 years.	Nov-25	902	922	919	750	972	983	1,031	1,098	1,114	899	992	947		682	-	n/a	n/a	-
	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Nov-25	1,282	1,167	1,091	659	990	1,443	1,325	1,242	941	677	444	319		-	0 by Sept 2024	523	9,394	
Cancer	Patients waiting more than 6 weeks for a diagnostic test	Nov-25	10.3%	11.2%	5.9%	6.7%	10.1%	12.0%	11.4%	11.2%	14.2%	12.4%	9.5%	9.2%		5.0%	5.0%	13.7%	21.7%	3/42
	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Oct-25	74.9%	71.6%	74.7%	76.4%	76.1%	75.0%	73.8%	75.4%	76.2%	72.7%	72.3%			74.2%	85.0%	70.5%	68.7%	11/42
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Oct-25	95.5%	92.8%	95.8%	95.3%	94.7%	95.5%	95.5%	95.2%	95.1%	93.7%	94.4%			96.0%	96.0%	95.0%	92.5%	17/42
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Oct-25	75.5%	66.8%	76.6%	76.3%	75.4%	71.8%	73.6%	71.7%	70.5%	70.6%	73.6%			78.7%	77% by Year end	75.5%	76.1%	32/42
Community	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028. (Rolling 12 months)	Sep-25	58.9%	58.8%	59.0%	59.2%	59.3%	59.4%	59.2%	58.6%	59.0%	59.3%				70.0%	75% by 2028	58.6%	59.5%	24/42
	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Nov-25	85%	84%	83%	85%	86%	86%	86%	87%	87%	88%	85%	84%		70.0%	70.0%	88.0%	84.0%	27/42
	Virtual Wards Utilisation	Nov-25	69.2%	94.7%	73.5%	83.1%	75.3%	74.7%	63.7%	78.9%	72.0%	72.9%	72.0%	99.8%		78.7%	80.0%	80.0%	79.8%	5/42
	Community Services Waiting List (Adults)	Oct-25	50,574	50,937	41,919	43,198	42,897	41,462	54,290	66,869	72,441	68,623	62,270					114,073	850,636	-
	Community services Waiting List (CYP)	Oct-25	22,834	23,164	20,184	20,110	20,519	21,794	24,606	25,457	19,198	19,103	20,279					42,206	304,042	-
Notes	Community Services – Adults waiting over 52 weeks	Oct-25	234	164	94	118	95	71	237	424	613	449	410			0		772	10,388	-
	* from BIP sentinel metric run report																			

1. ICB Aggregate Position

Category	Metric	Latest period	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Local Trajectory	National Target	Region value	National value	Latest Rank
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen in 2 weeks	Oct-25	78.0%	79.0%	79.0%	83.0%	77.0%	76.0%	69.0%	79.0%	80.0%	84%	76%			60.0%	60.0%	68.0%	73.7%	18/42
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	To Sep 2025	52.0%	62.0%		56.0%		53.0%								-	60.0%	56.0%	58.0%	36/42
	Dementia Diagnosis Rate	Nov-25	67.3%	67.2%	67.4%	67.6%	67.6%	67.6%	67.8%	68.0%	68.2%	68.1%	68.4%	68.4%		66.7%	66.7%	70.9%	66.5%	15/42
	CYP Eating Disorders Routine	Oct-25	89.0%	88.0%	87.0%	86.0%	92.0%	93.0%	93.0%	93.0%	94.0%	93.0%	92.0%			95.0%	95.0%	84.0%	81.0%	5/42
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Oct-25	34,550	34,710	34,550	34,625	35,450	35,185	35,485	35,090	35,105	35,220	35,940			37246	-	124610	852742	-
	Number of people accessing specialist Community PMH and MMHS services	Oct-25	3,555	3,530	3,555	3,625	3,620	3,600	3,645	3,635	3,655	3,675	3,465			3420	-	8705	66370	-
	Talking Therapies 1st to 2nd Treatment >90 days (NEW)	Oct-25	31%	32%	32%	31%	36%	31%	30%	19%	15%	17%	15%			-	10%	26%	22.8%	16/42
	Talking Therapies completing a course of treatment - % of plan achieved	Oct-25	92.0%	92.0%	92.0%	91.0%	102.0%	97.0%	104.0%	98.0%	95.0%	97.0%	99.0%			100.0%	100.0%	100.0%	98.0%	24/42
	Talking Therapies Reliable Recovery	Oct-25	45.0%	47.0%	47.0%	49.0%	48.0%	48.0%	48.0%	47.0%	47.0%	44.0%	47.0%			48.0%	48.0%	45.0%	47.0%	24/42
	Talking Therapies Reliable Improvement	Oct-25	65.0%	66.0%	68.0%	68.0%	67.0%	68.0%	68.0%	67.0%	66.0%	64.0%	67.0%			67.0%	67.0%	67.0%	67.8%	26/42
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Nov-25	85	80	80	80	80	75	75	75	75	75	75	75		46	-	225	1,820	16/42
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Oct 25 YTD	52.7%	63.0%	73.3%	85.5%	3.1%	7.5%	12.7%	18.5%	23.4%	31.1%	38.3%			31.6%	75% by Year end	40.1%	38.4%	20/42
Primary Care	Units of dental activity delivered as a proportion of all units of dental activity contracted	Nov-25	78.0%	82.0%	94.0%	95.0%	82.0%	81.0%	80.0%	79.0%	76.0%	77.0%	77.0%	68.0%		80.0%	100.0%	73.0%	72.0%	33/44
	Number of unique patients seen by an NHS Dentist – Adults (24 month)	Nov-25	933,534	934,964	936,873	937,773	940,716	941,167	941,865	944,188	944,222	944,793	947,424	944,820		946,893		2,656,334	18,158,984	-
	Number of unique patients seen by an NHS Dentist – Children (12 month)	Nov-25	331,503	332,275	332,480	333,475	333,796	333,871	334,907	335,719	336,135	336,563	338,282	336,705		342,511		1,035,414	7,233,686	-
	Appointments in General Practice & Primary Care networks	Nov-25	1,191,861	1,401,109	1,258,627	1,342,136	1,237,198	1,220,981	1,272,114	1,377,472	1,167,168	1,364,319	1,688,291	1,337,009		1,333,168		-	-	-
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Sep-25	6.94%	6.98%	7.02%	7.09%	7.14%	7.18%	7.22%	7.28%	7.29%	7.29%				10.0%	10.0%	-	7.62% (Dec 24)	-
	Total volume of antibiotic prescribing in primary care	Sep-25	1.01	0.99	0.98	0.97	0.95	0.94	0.94	0.93	0.92	0.92				0.871	0.871	-	1.00	-
Integrated care BCF metrics	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (average of place rates) (New data source)	Sep-25	238	216	220	239	229	232	237	228	208	191				-	-	-	175.7	-
	Percentage of people who are discharged from acute hospital to their usual place of residence (New data source)	Sep-25	80.5%	78.9%	80.4%	80.5%	82.3%	82.3%	83.1%	82.3%	83.0%	82.0%				-	-	-	81.5%	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (average of place rates) (New data source)	Aug-25	163	133	116	127	145	147	132	138	138					-	-	-	135.0	-
Note/s																				

1. ICB Aggregate Position

Category	Metric	Latest period	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Local Trajectory	National Target	Region value	National value	Latest Rank
Specialised Commissioning	Cardiac Treatment waiting list (LH&CH) ^	Oct-25	401	389	386	376	363	383	403	402	402	398	395			410				-
	Neurosurgery waiting list (TWC) ^	Oct-25	914	927	921	967	974	950	993	1,006	1,021	989	1,023			885				-
	Specialised Paediatrics waiting list (AHCH) ^	Oct-25	261	256	269	248	238	221	203	180	180	207	225			287				-
	Vascular waiting list (LUFT) ^	Oct-25	153	166	167	180	160	183	182	213	214	197	176			145				-
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q1 25/26	65.50%	69.07%			67.34%									77.0%	80.0%	68.51%	68.3%	27/42
	CVD treated to cholesterol threshold LDL-cholesterol less than or equal to 2.0 mmol/l or non-HDL cholesterol less than or equal to 2.6 mmol/l) (NEW)	Q1 25/26	44.8%	46.0%			45.6%										50.0%	47.1%	47.61%	28/42
	Smoking at Time of Delivery V2	Q2 25/26	6.1%	5.9%			5.4%			4.8%						-	6.0%	4.9%	4.30%	28/42
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.(Aged 15+) ~	Nov-25	13.5%	13.5%	13.4%				14.0%	14.0%	14.0%	13.9%	13.8%	16.4%		12.0%	12.0%	-	12.7% [^]	-
Continuing Healthcare	Standard Referrals completed within 28 days	Q2 25/26	73.10%	76%			71.70%			70.40%						80.0%	>80%	80.0%	76.0%	27/42
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q2 25/26	27.18	27.04			23.78			23.85						18.00		20.30	16.58	36/42
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q2 25/26	53.85	54.67			54.27			53.8						34.00		45.60	33.30	40/42
Maternity	HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks)	Q2 25/26	0.9	0.5			0.7			0.7						2.5	2.5	1.0		
	Still birth per 1,000 (rolling 12 months) (GP Reg MSDS)	Sep-25	2.34	2.44	2.54	2.49	2.41	2.43	2.49	2.44	2.54	2.56				-	2.6*	-	3.8	-
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Place aggregation (All cases)	12 months to Oct 25	1205	1198	1210	1191	1155	1143	1133	1134	1129	1108	1090			843		3037	17599	
	Healthcare Acquired Infections: E.Coli Place aggregation (All cases)	12 months to Oct 25	2367	2352	2333	2330	2330	2326	2330	2297	2325	2334	2320			2001		5909	44725	
	Summary Hospital-level Mortality Rate (SHMR) - Deaths associated with hospitalisation #	Jul-25	0.986	0.997	0.988	0.986	0.989	0.996	0.989	0.989						0.887 to 1.127 *		-	1.000	-
	Never Events	Nov-25	0	6	1	2	0	5	3	2	0	3	1	2		0	0	-	-	-
Workforce / HR (ICS total)	Staff in post	Nov-25	74,101	74,208	74,450	74,600	74,524	74,471	74,458	74,346	74,372	74,426	74,646	74,572		73,678		-		
	Bank	Nov-25	4,848	5,000	5,289	5,459	5,216	4,852	4,566	4,782	4,830	4,762	4,616	4,600		4,378		-		
	Agency	Nov-25	824	838	775	749	638	620	602	555	513	490	474	420		646.2		-		
	Turnover	Oct-25	10.7%			10.4%	10.1%	10.0%	9.9%	9.8%	9.7%	9.7%	9.5%			11.3%		-		
	Sickness##	Oct-25	5.6%	6.2%	5.7%	6.1%	6.1%	6.1%	6.1%	6.1%	6.2%	6.2%	6.2%			5.8%		-		
Notes	^ RAG rating based on 12 month comparison (Red = Higher, Green = Lower) # Banding changed Aug 23 to reflect SOF bandings for providers. Green = no providers higher than expected, Amber = 1-2 providers higher than expected, Red = more than 2 providers higher than expected ~ New methodology from June, data now reported in line with CIPHA ## latest rank, region and national values are one month behind latest data * Original NHS target was to halve the 2010 stillbirth rate of 5.1 per 1,000 by 2025. replaced with a reduction to 2.3 per 1,000 by 2030																			

2. ICB Aggregate Financial Position

ICB Overall Financial Position:

Category	Metric	Latest period	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Plan (£m)	Dir. Of Travel	FOT (£m) Plan	FOT (£m) Current	FOT (£m) Variance
Finance	Financial position £m (ICS) ACTUAL	Oct-25	-129.7	-109.7	-89.7	-45.9	-	-37.4	-51.7	-78.4	-110.4	-124.8	-138.0	-159.0		-82.3	⬇️	0.0	0.0	0.0
	Financial position £ms (ICS) VARIANCE	Oct-25	-61.2	-47.3	-33.2	-45.9	-	0.2	1.4	-17.3	-35.6	-42.6	-59.4	-76.7			⬇️			
	Efficiencies £ms (ICS) ACTUAL	Oct-25	276.6	321.3	362.7	417.1	-	61.0	98.1	147.8	180.7	226.1	264.3	312.4		324.1	↗️	572.5	581.1	8.6
	Efficiencies £ms (ICS) VARIANCE	Oct-25	-20.7	-23.4	-29.4	-22.8	-	-1.9	1.0	9.3	0.0	2.2	-9.6	-11.7			⬇️			
	Capital £ms (ICS) ACTUAL	Oct-25	170.0	204.1	241.0	327.0	-	-	-							-	-	236.8	239.9	-3.1
	Capital £ms (ICS) VARIANCE		32.1	24.6	10.9	-16.7	-	-	-							-	-	N/A	N/A	

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

Category	Metric	Latest period	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Vs Target expenditure (Current)	Vs Target expenditure (Previous)	Dir. Of Travel
Finance	Mental Health Investment Standard met/not met (MHIS)	May-25	Yes	Yes	Yes	Yes	-	Yes		Yes	Yes	↔️						
	BCF achievement (Places achieving expenditure target)	May-25	9/9	9/9	9/9	9/9	-	9/9	9/9	9/9	9/9	9/9	9/9	9/9		9/9	9/9	↔️

3. Provider / Trust Aggregate Position

Category	Metric	Latest period	Providers																		Net OOA/ Other/ ICB	ICB *		
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts									
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP						
NHS SOF	Segment@	25/26 Q2	④	④	④	④	④	④	③	①	①	④	①	①	③	①	②	③						
	Segment movement from previous quarter (NEW)	25/26 Q2	→	✗	✗	→	→	→	→	→	→	✗	→	→	→	→	→	↗						
Urgent care	4-hour A&E waiting time % waiting less than 4 hours	Dec-25	61.9%	52.2%	63.0%	69.6%	67.3%	71.9%	75.4%	89.5%		87.0%	-	-	-	-	-	-	-	-	71.5%			
	Mean Ambulance Handover time (ED and Non ED)	Dec-25	00:30:31	00:27:53	00:23:58	00:36:29	00:35:51	00:41:20	00:51:12	00:23:03												00:38:39		
	A&E 12 hour waits from arrival	Dec-25	23.0%	15.3%	16.0%	23.3%	22.9%	16.2%	20.9%	0.4%	-	0.0%	-	-	-	-	-	-	-	-	-	17.4%		
	Adult G&A bed occupancy	Dec-25	97.7%	97.0%	94.2%	94.1%	95.6%	94.3%	96.8%	-	79.0%	55.6%	84.6%	85.2%								-	94.3%	
	Percentage of beds occupied by patients no longer meeting the criteria to reside (NEW - rolling 7-day average last week of month)	Dec-25	20.6%	15.3%	16.1%	14.8%	21.3%	20.3%	19.5%													-	18.7%	
	Discharges - Average delay (exclude zero delay)	Nov-25	12.9	11.0	**	4.5	8.4	6.1	9.6	0.0	5.9	1.5	0.0	0.0								8.2		
	Percentage of patients discharged on discharge ready date	Nov-25	83.7%	79.6%	**	91.1%	83.6%	83.9%	84.1%	100.0%	98.4%	90.1%	100.0%	100.0%									85.9%	
Planned care	Total incomplete Referral to Treatment (RTT) pathways	Nov-25	31,747	19,399	41,889	48,066	32,589	63,650	74,838	16,892	4,876	14,203	934	14,020					53		-	355,626		
	The % of people waiting less than 18 weeks on the waiting list (RTT)	Nov-25	53.0%	51.2%	54.6%	59.6%	60.6%	56.5%	62.7%	61.9%	77.5%	48.8%	96.7%	63.2%								98.1%		
	The % of people waiting more than 52 weeks on the waiting list (RTT)	Nov-25	5.8%	3.4%	2.7%	2.7%	3.3%	2.4%	2.0%	1.6%	0.8%	9.1%	0.0%	0.7%					0.0%			2.9%		
	Number of 52+ week RTT waits, of which children under 18 years.	Nov-25	149	29	101	190	72	81	58	263	0	2	0	2								947		
	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Nov-25	98	8	137	25	11	10	1	0	0	5	0	2					0			319		
	Patients waiting more than 6 weeks for a diagnostic test	Nov-25	25.3%	15.3%	11.7%	5.3%	3.6%	7.0%	5.9%	3.8%	0.7%	9.4%	0.0%	0.6%	8.0%	0.0%	-	-	-	-		9.2%		
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Oct-25	73.1%	65.5%	54.6%	75.4%	85.6%	75.1%	75.4%	100.0%	88.9%	49.0%	83.1%	100.0%	63.6%							-	72.3%	
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Oct-25	92.6%	99.0%	72.4%	93.5%	97.4%	88.0%	93.1%	100.0%	100.0%	94.7%	99.5%	100.0%	12.5%							-	94.4%	
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Oct-25	77.9%	76.6%	75.3%	66.1%	75.5%	77.9%	70.8%	100.0%	88.2%	64.2%	90.9%	100.0%	49.3%							-	73.6%	
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 (calendar YTD)	Aug-25	57.8%	65.4%	63.2%	59.8%	48.9%	56.8%	55.9%	25.0%	56.0%	75.2%	74.1%	-	100.0%	-							58.6%	
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics																							
	** Indicates that provider did not meet to DQ criteria and is excluded from the analysis																							
	@ NHS SOF Segments - Highest = 1 (Consistently high performing), 2 (Requires some improvement or support), 3 (Experiencing significant challenges and requires more intensive support), 4 (Mandated intensive support due to serious problems or risks to care quality)																							

3. Provider / Trust Aggregate Position

Category	Metric	Latest period	Providers																	Net OOA/ Other/ ICB	ICB *	
			Cheshire & Wirral Acute Trusts						Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts						
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP				
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Nov-25	83.0%	87.0%	87%	Community Service Providers only										98.0%	87.0%	78.0%	70%	87%	84.0%	
	Virtual Wards Utilisation ~	Nov-25	66.7%	88.0%	100.0%	88.0%	76.7%	82.5%	65.1%	100.0%											99.8%	
	Community Services Waiting List (Adults)	Oct-25	0	4,126	5,891		-	-	286	0	148	-	-	-	3,930	5,322	20,339	5,322	16906	62,270		
	Community services Waiting List (CYP)	Oct-25	1,495	511	2,922		-	-	633	5,107	0	-	-	-	4,815	216	935	216	3429	20,279		
	Community Services – Adults waiting over 52 weeks	Oct-25	0	2	0		-	-	4	0	0	-	-	-	92	0	0	0	312	410		
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen in 2 weeks	Oct-25			Mental Health service providers only										75.0%	77.0%	-		76%			
	CYP Eating Disorders Routine	Oct-25								87%							93.0%	100.0%			92.0%	
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Oct-25			1555				5125						1690		8935	8535	10100	35,940		
	Number of people accessing specialist Community PMH and MMHS services	Oct-25															2195	1305		3465		
	Talking Therapies completing a course of treatment - % of LTP trajectory	Oct-25								Just number available/ no target										99.0%		
	Talking Therapies Reliable Recovery	Oct-25																47.0%			47.0%	
	Talking Therapies Reliable Improvement	Oct-25																64.0%			67.0%	
Learning Disabilities	Inpatients with a learning disability and/or autism (rounded to nearest 5)	Nov-25								#							50	30		75		
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics # Value suppressed due to small numbers □ ~ NHSE published and MWL local BIP data are different, NHSE published MWL data includes 20 paediatric hospital at home beds which is not included in local BIP published data □																					

3. Provider / Trust Aggregate Position

Category	Metric	Latest period	Providers																			Net OOA/Other/ICB	ICB/ICS *		
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts										
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP							
Maternity	HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks)	25/26 Q2	0.0	0.0	0.0	0.0	3.1		4.0			0.0										0.7			
	Still birth per 1,000 (rolling 12 months)	Sep-25	2.74	0.84	3.49	4.92	2.49	-	3.13	-	-	4.43	-	-								2.56			
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation (Healthcare Associated)	12 months to Oct 25	69	24	41	152	72	193	117	19	4	2	22	12									727		
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Oct 25	46	26	52	94	76	266	155	11	7	4	31	11									779		
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation** #	Jul-25	0.8953	1.2226	0.9789	1.0306	1.0203	0.9623	0.9834														0.989		
	Never Events (rolling 12 month total)	12 Months to Nov 25	3	0	2	4	3	2	5	3	1	1	0	0	0	0	0	1				25			
Workforce / HR (Trust Figures)	Staff in post	Nov-25	4,515	2,423	5,128	5,905	4,273	14,255	9,663	4,226	1,914	1,737	1,896	1,509	1,307	1,442	10,490	3,892	-			73,678			
	Bank	Nov-25	318	193	389	292	406	934	704	78	73	49	12	73	21	36	799	223	-			4,378			
	Agency	Nov-25	8	34	73	23	49	95	42	3	3	3	2	11	1	1	55	17	-			646			
	Turnover	Oct-25	10.2%	11.1%	9.2%	10.0%	9.2%	8.5%	8.5%	9.6%	8.0%	10.8%	9.5%	12.1%	11.1%	11.4%	10.4%	9.4%	-			11.3%			
	Sickness (via Ops Plan Monitoring Dashboard)	Oct-25	5.5%	5.3%	5.5%	5.9%	6.1%	6.1%	6.4%	6.1%	4.9%	6.1%	5.1%	5.8%	7.2%	6.8%	7.7%	6.5%	-			5.8%			
Finance	Overall Financial position - YTD Surplus / (Deficit) (£m) (NEW) (including deficit support funding)	Nov-25	-22.21	-13.69	-23.98	-19.04	-24.36	-46.43	-36.58	0.42	5.69	-17.26	0.19	4.53	-2.90	1.05	4.24	-1.26				32.60	-158.98		
	Overall Financial position - YTD Surplus / (Deficit) (£m) (NEW) (excluding deficit support funding)	Nov-25	-27.12	-16.27	-29.74	-23.27	-28.94	-57.55	-44.13	0.42	5.69	-21.09	0.19	4.53	-2.90	1.05	4.24	-1.26				32.60	-203.54		
	Overall Financial position - YTD Variance from plan (£m) (NEW) (including deficit support funding)	Nov-25	-8.18	-4.56	-9.56	-15.80	-8.46	-18.54	-8.80	-0.01	0.01	-6.16	0.01	0.13	0.00	1.32	1.30	1.57	-1.00			-76.70			
	Efficiencies - YTD Variance from plan (£m)	Nov-25	-7.42	0.00	0.51	-0.00	0.01	4.46	1.86	-1.57	-0.67	0.84	-0.00	-0.00	0.03	-0.09	-0.73	0.65	-9.60			-11.80			
	Capital - YTD Variance from plan £m	Nov-25	0.46	1.02	2.41	0.99	1.66	3.86	3.45	-0.82	2.72	1.01	-1.36	1.42	0.76	1.14	0.92	0.85	0.00			20.50			
Notes	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics ** The SHMI banding gives an indication for each non-specialist trust on whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, was as expected when compared to the national baseline, as the UCL and LCL vary from trusts to trust. This "banding" is different to the "rate" used for the ICB on slide 5, therefore a comparison cannot be drawn between the two. # Banding changed Aug 23 to reflect SOF rating by NHSE. 'As expected' rating is RAG rated Green, 'Higher than expected' is RAG rated Red.																								

4. Place Aggregate Position

Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target			
			Cheshire & Wirral				Merseyside											
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton							
			East **	West **							South Sefton	S/port & Formby						
Urgent Care	4-hour A&E waiting time % waiting less than 4 hours	Dec-25	58.8%	62.3%	27.6%	57.8%	74.8%	69.3%	80.0%	72.5%	71.2%		71.5%	76.5%	78% by Year end			
	Ambulance category 2 mean response time	Nov-25	00:37:06		00:36:08	00:37:58	00:35:42	00:38:06	00:37:36	00:38:42	00:38:38		00:37:31		00:30:00			
	A&E 12 hour waits from arrival	Dec-25	16.6%		21.5%	20.1%	11.9%	23.9%	15.8%	23.9%	16.54%		17.4%	16.5%	-			
	Discharges - Average delay(exclude zero delay)	Nov-25	11.2	11.1	3.9	8.1	6.8	11.1	8.1	10.5	6.3		8.2	8.8				
	Percentage of patients discharged on discharge ready date	Nov-25	85.6%	85.9%	91.8%	85.2%	84.0%	85.4%	87.5%	88.1%	82.0%		85.9%	85%				
Planned Care	Total incomplete Referral to Treatment (RTT) pathways	Nov-25	112,225		52,568	27,572	55,213	28,301	22,985	20,472	36,290		355,626	346,113	-			
	The % of people waiting less than 18 weeks on the waiting list (RTT)	Nov-25	55.9%		60.3%	63.1%	57.7%	62.7%	60.8%	60.5%	57.9%	65.5%	59.1%	60.9%				
	The % of people waiting more than 52 weeks on the waiting list (RTT)	Nov-25	3.3%		2.6%	3.2%	3.2%	1.9%	2.5%	2.9%	4.0%		2.9%	2.1%				
	Patients waiting more than 6 weeks for a diagnostic test	Nov-25	14.5%		5.3%	3.2%	8.1%	5.2%	6.5%	7.7%	8.7%		9.2%	5.0%	5%			
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Oct-25	59.5%	66.2%	76.1%	75.0%	77.3%	80.8%	70.2%	89.8%	69.6%		72.3%	74.2%	85.0%			
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Oct-25	86.1%	86.9%	95.8%	93.8%	95.8%	96.0%	94.9%	100.0%	92.2%		94.4%	96.0%	96.0%			
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Oct-25	75.7%	76.9%	66.6%	67.3%	76.8%	79.2%	77.0%	76.8%	68.5%		73.6%	78.7%	77% by Year end			
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 (calendar YTD) (NEW)	Sept 25 YTD	61.0%		60.5%	57.4%	58.5%	58.5%	57.5%	53.8%	57.1%	57.9%	59.3%	70.0%	75% by 2028			
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Oct-25	87.2%	78.7%	87.5%	83.9%	79.0%	83.1%	89.9%	92.7%	80.1%		88.0%	70.0%	70.0%			
	Virtual Wards Utilisation Number only	Nov-25	82	75	44	32	68	35	7	12	18		372					
	Community Services Waiting List (Adults) - data only available at ICB/Provider level												62,270					
	Community services Waiting List (CYP) - data only available at ICB/Provider level												20,279					
	Community Services – Adults waiting over 52 weeks - data only available at ICB/Provider level												410					
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT.																	

4. Place Aggregate Position

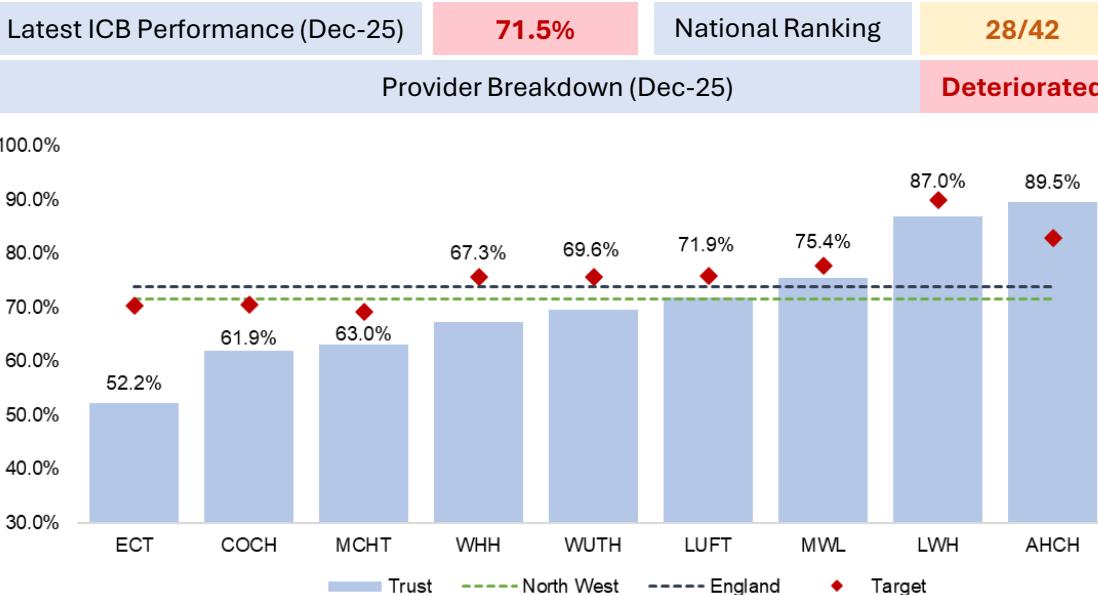
Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target			
			Cheshire & Wirral				Merseyside											
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton							
			East **	West **							South Sefton	S/Port & Formby						
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen in 2 weeks	Oct-25	81.0%		67.0%	*	79.0%	78.0%	73.0%	83.0%	70.0%	63.0%	76.0%	60.0%	60.0%			
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	To Sep 2025	52.0%		54.0%	57.0%	51.0%	47.0%	54.0%	65.0%	47.0%	63.0%	53.0%	-	60.0%			
	Dementia Diagnosis Rate	Nov-25	67.6%		66.9%	73.7%	69.6%	67.4%	67.2%	67.5%	68.60%		68.4%	66.7%	66.7%			
	CYP Eating Disorders Routine	Oct-25	100.0%		100.0%	100.0%	81.0%	95.0%	100.0%	100.0%	85.0%	100.0%	92.0%	95.0%	95.0%			
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Oct-25	6275		4625	3825	9040	4015	2675	1670	2440	1630	35940	37246	-			
	Number of people accessing specialist Community PMH and MMHS services	Oct-25	1035		385	280	635	280	275	180	245	145	3465	3420	-			
	Talking Therapies 1st to 2nd Treatment >90 days (NEW)	Oct-25	16%		1%	39%	2%	9%	13%	36%	34%	47%	15%		<=10%			
	Talking Therapies completing a course of treatment	Oct-25	5640		1975	1385	3975	1670	1155	670	1020	765	99.0%	100.0%	100.0%			
	Talking Therapies Reliable Recovery	Oct-25	51.0%		41%	48.0%	46.0%	47.0%	47.0%	50.0%	40.0%	51.0%	47.0%	48.0%	48.0%			
	Talking Therapies Reliable Improvement	Oct-25	72.0%		63.0%	69.0%	63.0%	66.0%	63.0%	69.0%	64.0%	69.0%	67.0%	67.0%	67.0%			
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Sep-25	20		10	5	20	5	10	5	5		75	46	-			
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Oct 25 YTD	37.1%		37.9%	34.3%	38.3%	34.5%	43.8%	38.8%	43.2%		38.3%	31.6%	75% by Year end			
Primary Care	Appointments in General Practice & Primary Care networks @	Nov-25	379,989		217,176	111,443	264,436	84,152	84,203	60,357	135,253		1,337,009	1,333,168				
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Sep-25	6.18%	7.40%	9.33%	6.30%	7.44%	6.28%	6.70%	6.53%	7.87%		7.29%	10.0%	10.0%			
	Total volume of antibiotic prescribing in primary care	Sep-25	0.78	0.86	1.02	0.82	0.92	1.10	1.11	0.96	0.95		0.92	0.871	0.871			
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6,7 and 8 for the ICB's latest position on the above metrics																	
	** Supressed due to small numbers																	
	@ RAG based on last year position, Green for greater than last year																	

4. Place Aggregate Position

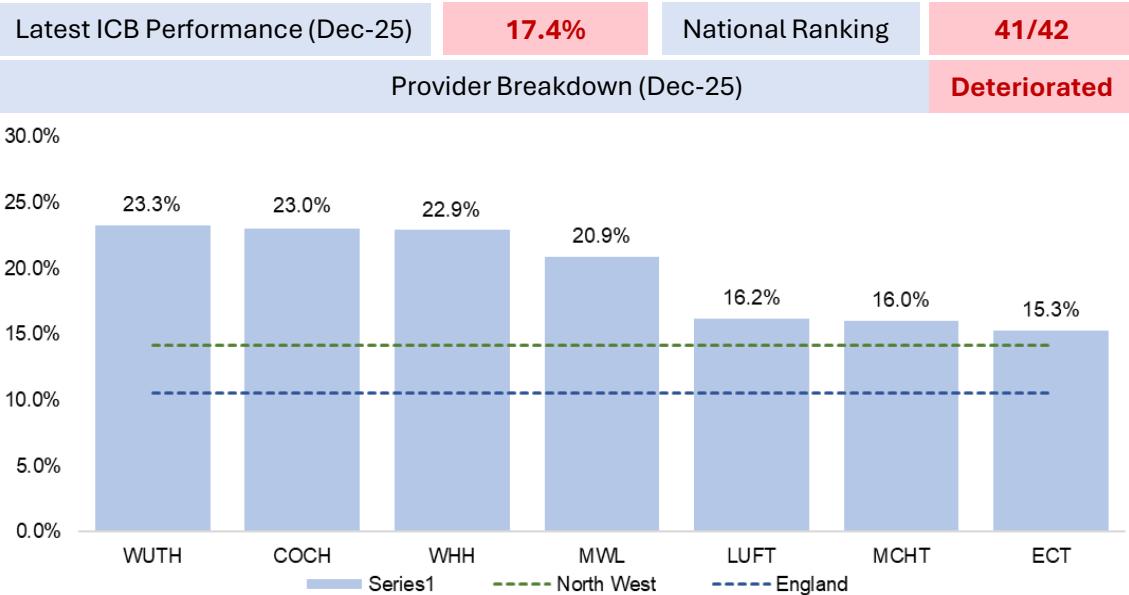
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			Cheshire & Wirral				Merseyside											
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton							
			East **	West **							South Sefton	S/Port & Formby						
Integrated care BCF metrics ***	Unplanned hospitalisation for chronic ambulatory care sensitive conditions Per 100,000 (New data source)	Sep-25	147.5	218.0	222.6	175.7	314.0	115.9	177.6	137.9	206.3		190.6	-	-			
	Percentage of people who are discharged from acute hospital to their usual place of residence (New data source)	Sep-25	74.3%	79.4%	85.7%	85.4%	84.6%	82.0%	81.7%	83.0%	82.1%		82.0%	-	-			
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (New data source)	Aug-25	115.9	118.3	148.4	117.1	166.6	103.0	142.1	157.6	176.8		138.4	-	-			
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q1 25/26	68.1%		66.1%	67.5%	67.5%	67.4%	68.4%	69.3%	64.9%		67.3%	77.0%	80.0%			
	CVD treated to cholesterol threshold: LDL-cholesterol less than or equal to 2.0 mmol/l or non-HDL cholesterol less than or equal to 2.6 mmol/l) (NEW)	Q1 25/26	46.2%		48.0%	44.1%	45.9%	43.5%	47.8%	45.3%	42.9%		45.6%		50%			
	Smoking at Time of Delivery	Q2 25/26	3.5%		6.9%	2.2%	4.5%	6.5%	7.8%	10.0%	4.5%		4.8%		<6%			
	Smoking prevalence (aged 15+) - As reported on CIPHA from GP Systems	Nov-25	13.80%		16.40%	16.40%	18.90%	16.10%	18.90%	19.30%	16.90%	15.90%	16.4%	12%	12%			
Continuing Healthcare	Standard Referrals completed within 28 days	Q2 25/26	62.7%		76.0%	80.3%	56.8%	89.7%	97.4%	87.5%	64.6%	68.8%	70.40%	>80%	>80%			
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q2 25/26	18.71		31.11	25.89	21.44	10.02	12.06	30.63	43.49	49.98	23.85	18				
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q2 25/26	63.4		70.8	42.9	47.9	27.3	32.9	45.7	55.0	69.6	53.80	34				
Quality & Safety	Still birth per 1,000 - (rolling 12 mths) (GP Reg MSDS)	Sep-25	2.16	2.29	4.23	1.13	3.78	2.62	0.68	0.00	2.47		2.56					
	Healthcare Acquired Infections: Clostridium Difficile - (All cases)	12 months to Oct 25	224		206	99	212	68	76	66	139		1090	843	-			
	Healthcare Acquired Infections: E.Coli - (All cases)	12 months to Oct 25	632		288	177	485	198	169	103	268		2320	2001				
Finance	Overall Financial position Variance (£m)	Nov-25	-6.9	-2.3	-5.1	-0.8	-5.8	-1.1	-2.0	-2.3	2.0		23.3	0.0	0.0			
	Efficiencies (Variance)	Nov-25	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	0.0	0.0			
	Mental Health Investment Standard met/not met (MHIS)	Nov-25	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Yes	Yes			
	BCF achievement (Places achieving expenditure target)	Nov-25	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	9/9	9/9			
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6,7 and 8 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. *** Local trajectories set by Place as part of their BCF submissions to NHSE, therefore RAG rating will vary for Places with lower/higher trajectories																	

5. Exception Report – Urgent Care

A&E 4 hour waits from arrival



A&E 12 hour waits from arrival



Issue

- A&E 4-hour performance across Cheshire and Merseyside has deteriorated to 71.5% in December 2025, placing the ICB 28th of 42 nationally and remaining well below the 78% national ambition. Performance continues to be driven by sustained high attendances, elevated bed occupancy, and delays in discharge, particularly impacting sites with high medical and frailty demand.
- A&E 12-hour waits from arrival remain unacceptably high at 17.4%, with the ICB now 41st of 42 nationally. Despite some site-level variation, this reflects ongoing system-wide flow constraints, including long-stay patients, constrained inpatient capacity, and variable performance across discharge pathways.

Actions:

- Mid Mersey (MWL):4-hour performance 75.4%; 12-hour waits 20.9%. Continued focus on ECIST-aligned admission and discharge criteria, NCTR improvement, strengthened Fit-to-Sit processes, and escalation discipline to reduce extended ED stays.
- East Cheshire (ECT):4-hour performance 52.2%; 12-hour waits 15.3%. Ongoing strengthening of front-door streaming, GP and Fit-to-Sit models, and alternative pathways to mitigate mental health escalation and improve flow from ED.
- Mid Cheshire (MCHT):4-hour performance 63.0%; 12-hour waits 16.0%. Continued emphasis on triage optimisation, rapid streaming, and reduction of prolonged waits, supported by GIRFT and ECIST interventions.
- Countess of Chester (COCH):4-hour performance 61.9%; 12-hour waits 23.0%. Sustained focus on front-door redesign, SDEC optimisation, and targeted review of long-wait cohorts under GIRFT guidance.
- Wirral (WUTH):4-hour performance 69.6%; 12-hour waits 23.3%. SDEC expansion and frailty pathway optimisation continue, with on-site GIRFT support to address prolonged waits and improve same-day outcomes.
- Liverpool (LUFT):4-hour performance 71.9%; 12-hour waits 16.2%. Continued focus on specialty-in-reach, improved access to community capacity, and discharge acceleration to reduce ED congestion.
- Warrington (WHH):4-hour performance 67.3%; 12-hour waits 22.9%. Ongoing implementation of ECIST recommendations, including triage redesign and workforce model changes to improve front-door flow.
- Liverpool Women's (LWH):4-hour performance 87.0%; no material 12-hour waits. Maintaining strong performance through focused operational grip and effective flow management.
- Alder Hey (AHCH):4-hour performance 89.5%, the highest across the system, with no reported 12-hour breaches, reflecting sustained paediatric flow controls and demand management

Delivery and Assurance

- Trust-level improvement plans continue to be delivered through targeted tests of change, workforce redesign, frailty and specialty pathway optimisation, and strengthened community and discharge responses.
- In day, System-wide recovery remains under daily oversight through the SCC, with escalation aligned to OPEL status, provider-specific action tracking, and regular regional engagement. Delivery is aligned to the 2025/26 UEC Improvement Plan and the NHSE Winter Assurance Framework, with a continued focus on reducing 12-hour waits and stabilising front-door performance

5. Exception Report – Urgent Care

Ambulance category 2 mean response time

Latest ICB Performance (Dec-25)

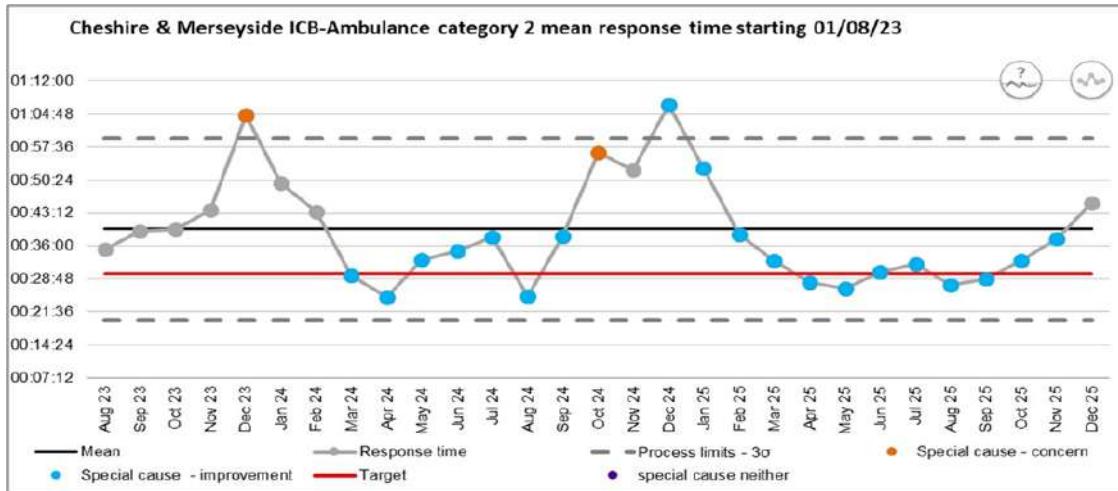
00:45:25

National Ranking

41/42

ICB Trend (Dec-25)

Deteriorated



Issue

- Cheshire and Merseyside's Category 2 mean response time deteriorated to 00:45:25 in December 2025, placing the ICB 41st of 42 nationally and remaining **above the 30-minute national standard**.
- Performance reflects **sustained system pressure**, including high incident volumes, prolonged hospital handovers, and variable locality performance. While some stabilisation is evident compared to earlier peaks, **overall performance remains fragile and below required levels**.

Actions

- Targeted HO45 actions across all acute sites** with HO45 being relaunched across sites during the December MADE / RESET events carried out to maximise discharges and reduce occupancy.
- NWAS and system partners** are implementing enhanced Cat 2 call stack management and escalation protocols ensuring senior clinical oversight of long waits and improved prioritisation during peak period of demand.

Delivery

- Real time monitoring** of ambulance handovers continues via SCC.
- UEC SROS** remain embedded in daily flow and demand reviews.
- Further improvements in **ED flow, discharge acceleration and EDD reliability** are expected to support reduced handover delays and improvement Cat 2 performance over the remainder of winter.

Adult G&A bed occupancy

Latest ICB Performance (Dec-25)

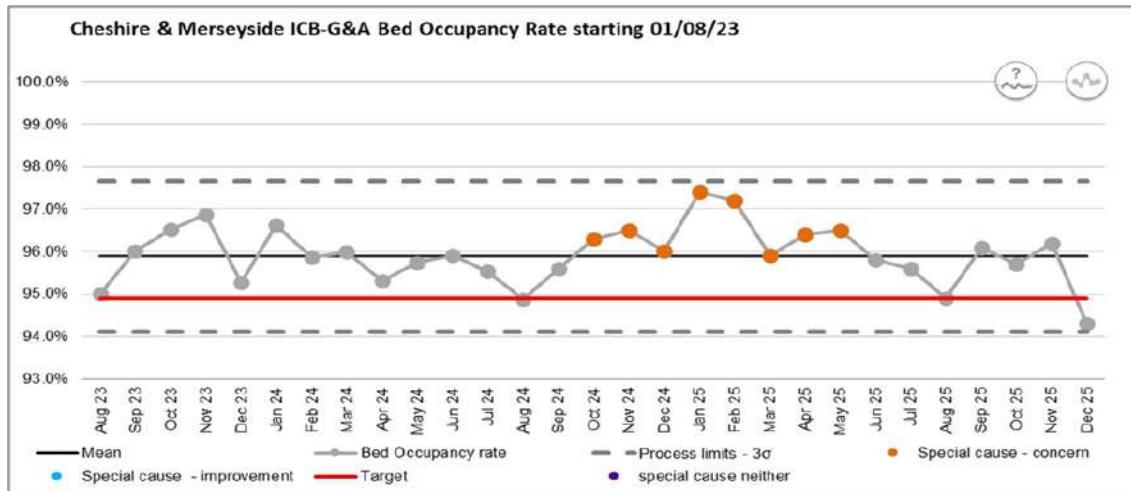
94.3%

National Ranking

23/42

ICB Trend (Dec-25)

Improved



Issue

- Adult G&A bed occupancy improved to 94.3% in December 2025, with the ICB now 23rd of 42 nationally.
- Despite improvement, occupancy remains **materially above the optimal 92–93% threshold**, continuing to constrain patient flow, delay admissions from ED, and contribute to ambulance handover delays.
- Sites report **persistent front-door pressure, variable early discharge performance**, and inconsistent delivery of internal flow processes, resulting in day-to-day volatility and reduced resilience during winter surges.

Actions

- All trusts **set trajectories to achieve 92% occupancy**, with the exception of **Countess of Chester**, reflecting local capacity constraints.
- Warrington (WHH)**: System-wide **MADE events** delivered with additional focus on 7-day flow and discharge optimisation.
- Wirral (WUTH)**: Implementation of a **new 21-day CRTR review process**, supported by **GIRFT**.
- Liverpool (LUFT)**: **Overnight GP streaming** introduced alongside continued flow model refinement.
- East Cheshire (ECT)**: Implementation of **clinical criteria for discharge** and targeted **MADE events**.
- Mid Mersey (MWL)**: **Embedded EDD discipline and Pathway 0 tracking**, with ward and board round standards rolled out to additional wards.
- Mid Cheshire (MCHT)**: **MADE events and strengthened board round focus** to accelerate discharge and reduce unwarranted delay.

Delivery and Assurance

- The system remains focused on driving occupancy down towards 92%, supported by **strengthened leadership grip, daily SCC monitoring calls**, and escalation aligned to OPEL status.

5. Exception Report – Urgent Care

Percentage of beds occupied by patients no longer meeting the criteria to reside

Latest ICB Performance (Dec-25)

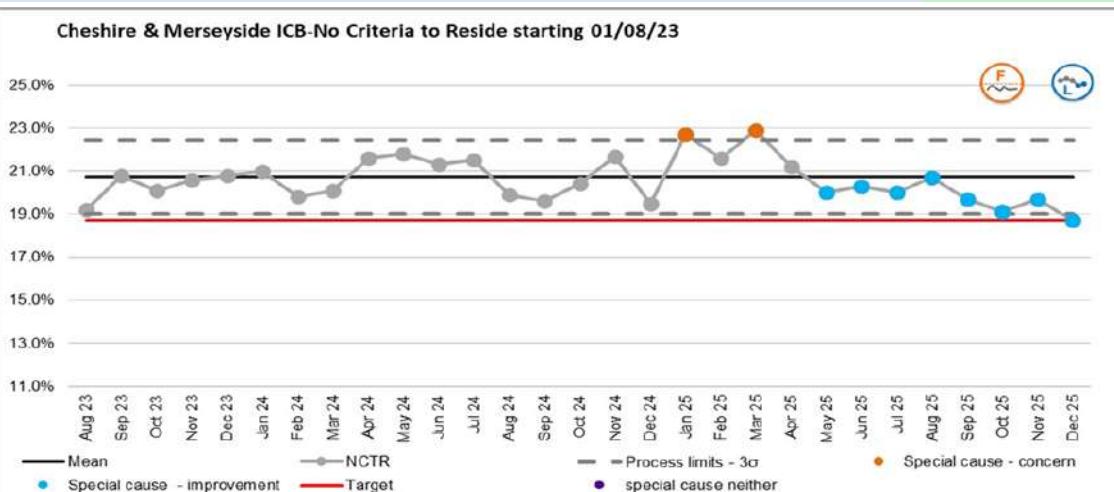
18.7%

National Ranking

n/a

ICB Trend (Dec-25)

Improved



Issue

- NCTR patients account for 18.7% of occupied beds in December 2025, demonstrating an **improving trend month-on-month** and remaining below the upper process control limit.
- Despite improvement, performance **remains materially above the 12% system ambition**, indicating ongoing delays for patients who are clinically optimised but unable to progress through discharge pathways.
- Detailed analysis confirms that NCTR pressure continues to be driven by a **small number of high-volume root causes**, primarily: **Pathway 3 (complex rehabilitation / long-term care) delays**. **Pathway 1 delays**, linked to availability and timeliness of domiciliary care and supported discharge packages. **Delays awaiting confirmation or acceptance from the Care Transfer Hub. Therapy decision or review delays**, particularly at weekends and during surge periods.

Actions

- Daily NCTR escalation calls** continue to focus on the highest-volume delay categories, with targeted improvement activity on **Pathway 1 and Pathway 3** at each acute site.
- Local authority and community partners** are actively engaged through **weekly discharge cells**, accelerating allocation of homecare, interim placements, and bed-based capacity, with senior oversight.
- Care Transfer Hubs** are enhancing referral triage, daily oversight, and turnaround times to reduce hand-off delays.
- Trusted Assessor and Discharge to Assess models** continue to be embedded to streamline assessments, reduce duplication, and target the highest-impact delay cohorts.

Delivery and Assurance

- The **sustained month-on-month improvement** provides assurance that current interventions are having impact, though progress remains fragile under winter demand.

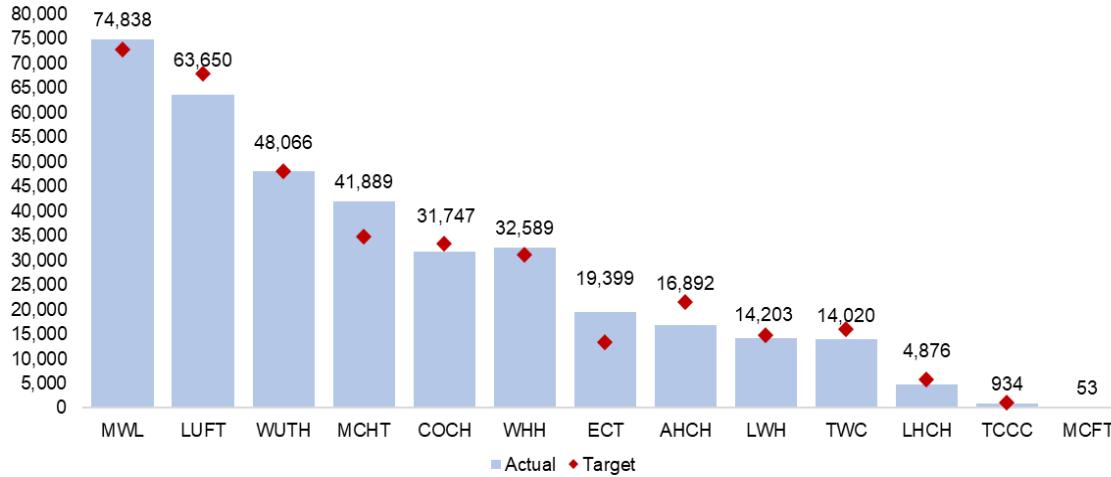
5. Exception Report – Planned Care

Total incomplete Referral to Treatment (RTT) pathways

Latest ICB Performance (Nov-25) **355,626** National Ranking **n/a**

Provider Breakdown (Nov-25)

Improved



Issue

- The total wait list size in November was 351,386. This is 26,101 less than a revised trajectory of 377,487 (following revision of Sep, Oct & Nov trajectories requested by NHSE (not shown above)).
- There is a risk that waiting list numbers will exceed planned trajectories from December onwards. This is largely driven by waiting list growth at Mid Cheshire and East Cheshire Hospitals following implementation of their Digital Clinical System. Data Quality issues account for approx. 60% of growth, with reduced levels of activity accounting for approx. 40% of growth.

Action

- Recovery plans were requested from high-risk providers to achieve a return to plan by the end of March 26 at the latest, inclusive of a waterfall chart to reduce the total waiting list position.
- The C&M H2 Elective Recovery plan with additional NHSE funding to support increased clinical triage of patients waiting >27wks for ENT, Gynae and Dermatology (approx. 19k patients) – achieving between 20 to 30% removals has been mobilised and is underway.
- A System Capacity Management Process is being implemented to increase utilisation of elective hubs and inter-organisational support. Additional regional funding will be used to provide increased capacity across the system to help reduce long waiters and WL size.

Delivery

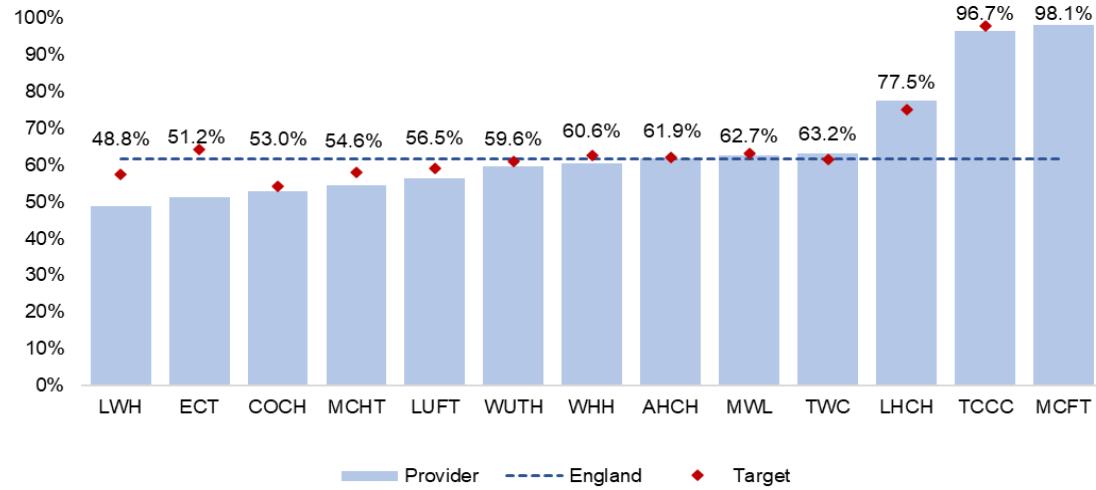
- This will be delivered via a C&M Clinical Operational Group and monitored via the CMPC Chief Operating Officer Group and Delivery Board.

The % of people waiting less than 18 weeks on the waiting list

Latest ICB Performance (Nov-25) **59.1%** National Ranking **35/42**

Provider Breakdown (Nov-25)

Deteriorated



Issue

- Several trusts are behind plan for the % of people waiting less than 18-week on the waiting list.
- Mid Cheshire & East Cheshire Trusts are deploying new trust-wide EPR systems, both providers are experiencing challenges due to DCS implementation.

Action

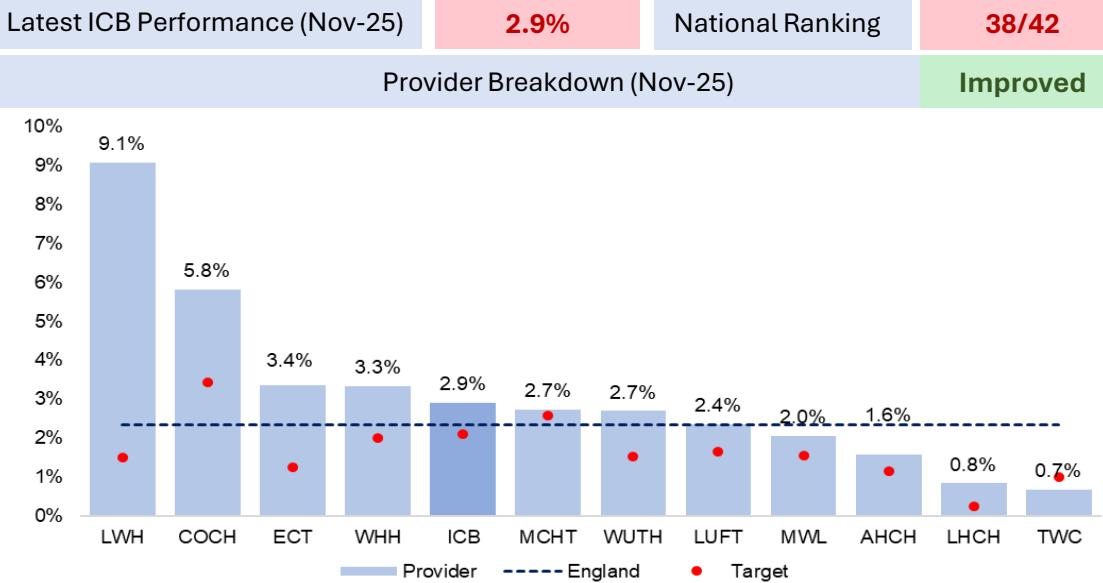
- 6 Trusts are currently in NHSE Tiering with improvement plans in place and regular oversight meetings. CMPC & ICB representatives attend and provide support where required.
- The CMPC Elective team hold two-weekly calls with all providers to review performance and to provide support for any escalated actions.
- All providers are participating in the national Q4 validation sprint to help manage demand and improve performance.
- The H2 Elective Recovery Plan is designed to help manage demand and increase capacity to improve performance. In addition, there are productivity improvements schemes for ENT, Gynae & T&O to increase clinic and theatre utilisation.
- The Q4 sprint launched by NHSE is focused on additional activity to improve RTT performance by March 2026. C&M Trusts are currently working through their submissions to support the sprint.

Delivery

- This will be delivered via a C&M Clinical Operational Group and Theatres Improvement Group and monitored via the CMPC COO Group and Delivery Board.

5. Exception Report – Planned Care

The % of people waiting more than 52 weeks on the waiting list (RTT)



Issue

- While the current performance is behind plan, performance has improved (2.6% as of 4th January 2026). In November 25, there were 10,140 patients waiting over 52 weeks.
- Liverpool Women's is furthest off plan (+7.8%) due to cessation of insourcing earlier in the year.
- Mid Cheshire & East Cheshire Trusts are deploying new trust-wide EPR systems, both providers are experiencing challenges due to DCS implementation.

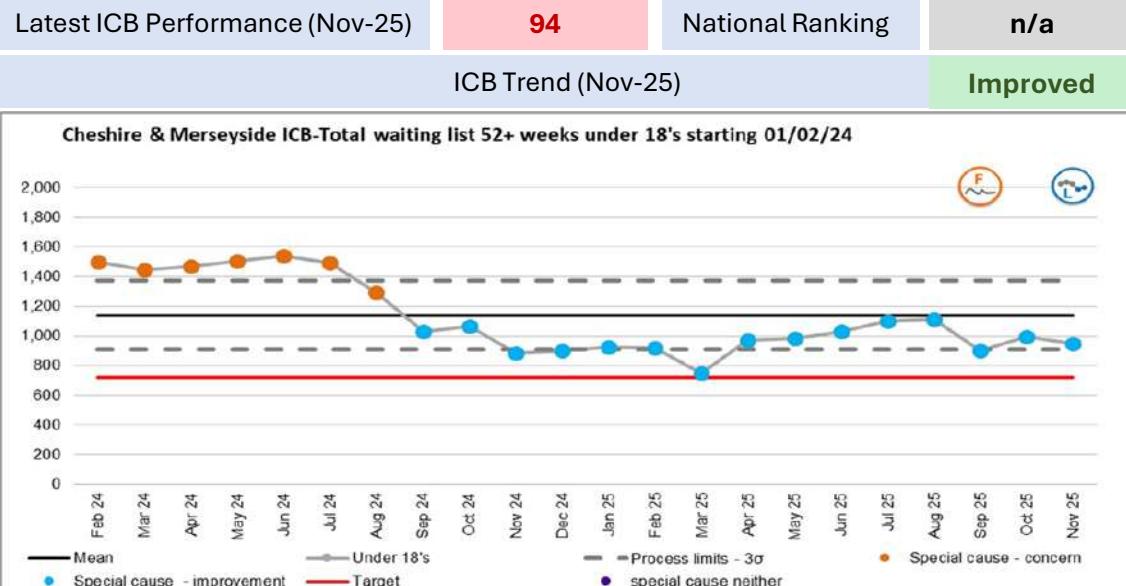
Action

- 6 Trusts are currently in NHSE Tiering with associated improvement plans and regular oversight meetings. The CMPC Elective team hold two-weekly calls with all providers to review performance and to provide support for any escalated actions.
- The C&M H2 Elective Recovery plan with additional NHSE funding to support increased clinical triage of patients waiting >27wks for ENT, Gynae and Dermatology (approx. 19k patients) – achieving between 20 to 30% removals has been mobilised and is underway.
- A System Capacity Management Process is being implemented to increase utilisation of elective hubs and inter-organisational support. Additional regional funding will be used to provide increased capacity across the system to help reduce long waiters and WL size.
- A C&M Elective Hub Improvement Group has been established, and all hubs have an agreed improvement plan and trajectory to achieve 85% by end of March 26.

Delivery

- Delivered via C&M Clinical Operational Group, monitored via CMPC COO Group & Delivery Board.

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



Issue

- Several organisations are off plan in relation to their 52 week-long waits position. In November 25, there are 947 CYP patients waiting over 52 weeks (52wk performance for CYP is marginally better than for adults).

Action

- The elective reform team have bi-weekly meetings with all C&M providers to review their plan vs actual position, to ensure specific recovery actions are managed and overseen with system support in place when required.
- Managing long waits across some key specialties at system level continues to be challenged, with all providers reporting challenges within ENT and Dental pathways.
- Significant improvements in the current waiting position were delivered in FY 24/25 with a continued focus in 25/26.
- The H2 Elective Recovery Plan described opposite is inclusive of CYP and will include specific actions for CYP long waiters in ENT and dental.

Delivery

- This will be delivered via a C&M Clinical Operational Group and monitored via the CMPC COO Group and Delivery Board

5. Exception Report – Planned Care

ICB incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Nov-25)

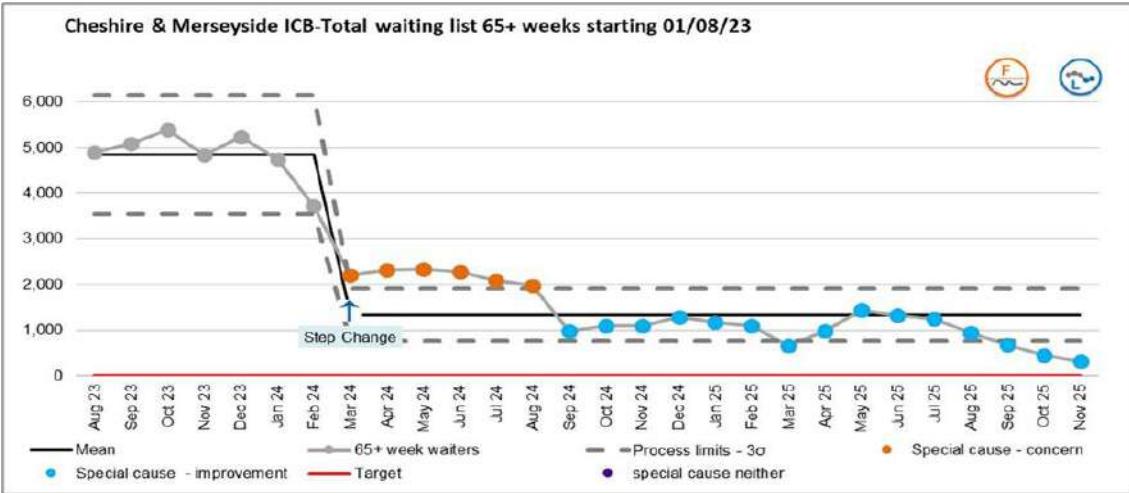
319

National Ranking

n/a

ICB Trend (Nov-25)

Improved



Trust incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Nov-25)

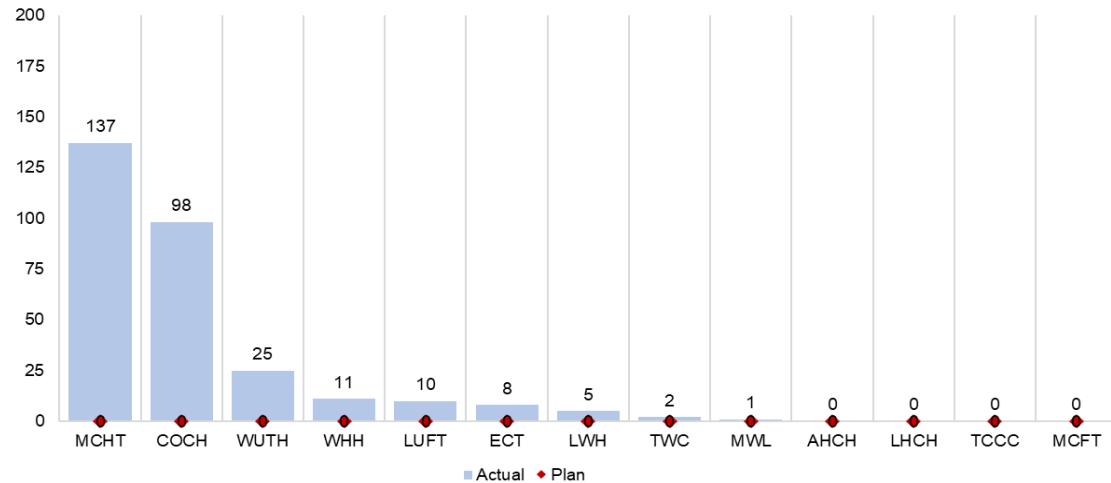
319

National Ranking

n/a

Provider Breakdown (Nov-25)

Improved



Issue

- There were 262 patients waiting 65wks+ as of November 25.
- The largest proportion of 65wks is at Mid-Cheshire Trust (150). The implementation of a new Digital Clinical System and cessation of insourcing/outsourcing earlier in the year has caused significant challenges.
- Data quality and accurate forecasting to underpin improvement work has been a challenge. Significant improvements have been made across all providers.

Action

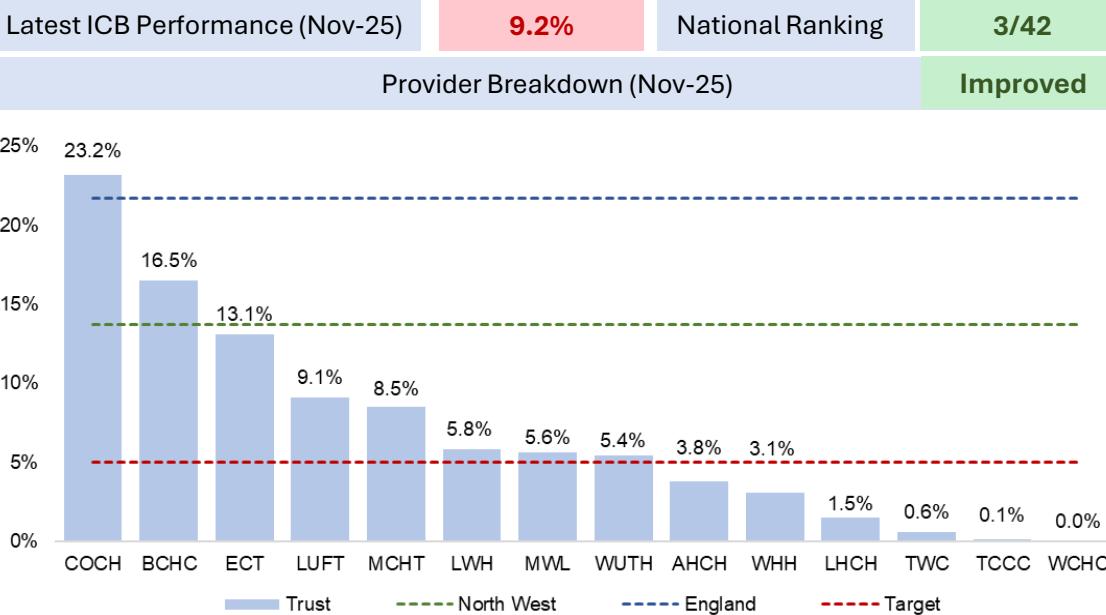
- Weekly Performance & Delivery meeting continue which all providers attend to update on their current position, escalate issues and request mutual aid. This has delivered significant improvements in 65wk performance during the last three months.
- 6 Trusts are currently in NHSE Tiering with improvement plans in place and regular oversight meetings. CMPC & ICB representatives attend and provide support where required.
- The elective programme is working closely with providers to ensure that mutual aid and operational tactical measures are explored and expedited. Active mutual aid is being supported for Liverpool Women's Hospital in relation to Gynaecology.
- CMPC continues to prioritise validation activity with current performance reporting at 12-weeks 65.10%, 26-weeks 72.93% (5 providers reporting above national ambition of 90%) and 52-weeks 93.94%, (with 8 providers reporting above the national ambition of 90%) (no submission from ECHT & MCHT due to implementation of new EPR system).
- The implementation of the C&M H2 Elective Recovery Plan will support further improvements in 65wk performance and mitigate future risks for further 65wk breaches.
- The North West ranked number 1 of 7 Regions for 65-week delivery at the end of December which is inclusive of the position that C&M concluded the month at.
- 65-weeks breaches in C&M have been reduced from a position of 1,311 in July 2025 to 48 at the end of December 2025 (compared with 28 in L&SC and 39 in GM).

Delivery

- There is a continued focus on eradicating 65 week waits and to model the delivery of 52 and 18 weeks for future planning.
- This will be monitored via the CMPC COO Group and Delivery Board
- CMPC continues to report into region on current performance and plans for immediate recovery.

5. Exception Report – Diagnostics & Cancer

Patients waiting more than 6 weeks for a diagnostic test



Issue

- C&M performance has deteriorated since March, for various reasons including financial constraints reducing any waiting list initiatives and other premium rate activity alongside significant workforce challenges in some tests. C&M remain in the top 5 ICB areas nationally for diagnostic performance.
- Performance at Countess of Chester Hospital remains a challenge across several diagnostic tests, this is due to workforce related issues and financial constraints. The Trust is being supported by the Mutual Aid process across several tests.

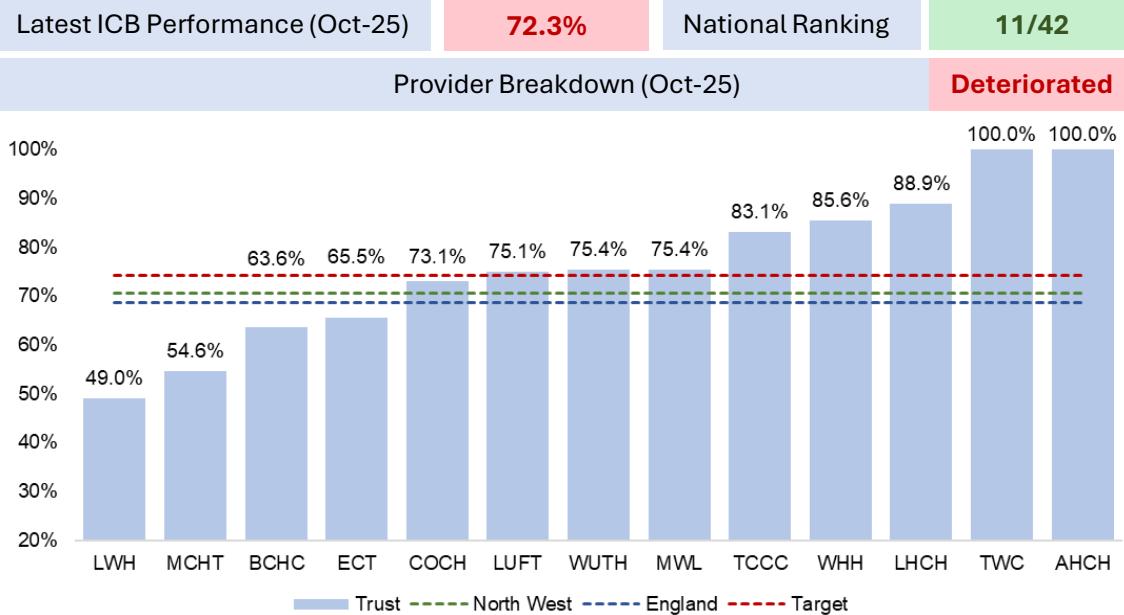
Action

- Mutual Aid Process – refreshed support for the process signed off at Diagnostic Delivery Board in November with implementation underway and excess capacity in CDCs being exhausted through the process.
- Increasing number of patients being referred from C&M Trusts to the Halton Endoscopy Hub for earlier access to surveillance and diagnostic Endoscopy tests.
- Medium term planning underway with all Providers being supported by the Diagnostic Programme to ensure sufficient diagnostic capacity is included in Provider plans. CDC packs shared with CDC Leads which highlights system pressures and PLACE specific pressures to increase activity in these tests.

Delivery

- No national diagnostic performance target set by NHSE for 25/26. However, clear targets have been set for diagnostic performance for 26/27, 27/28 and 28/29 and the Diagnostic Programme are working with Providers to ensure sufficient activity will be provided to meet the targets in these years.

2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer



Issue

- C&M not yet achieving the 85% 62-day combined standard required. This is 75% at the end of year point for 25/26. The figure of 72.3% is 4th amongst Cancer Alliances and 11th amongst ICBs. It should be noted that this figure is 4.8% points ahead of England and represents good performance for C&M in relative terms. Despite a deterioration, the ranking has improved.

Action

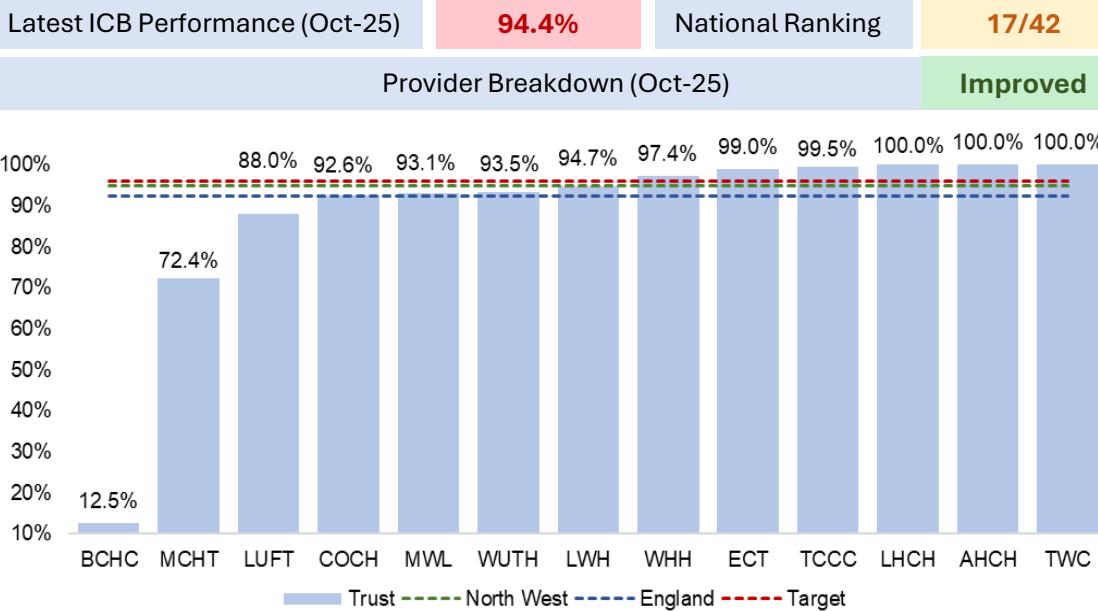
- November forecasts show recovery back above trajectory
- Capacity and demand exercises for 25/26 are addressing this and short-term investment is being made by the Cancer Alliance in key areas however, this is limited due to reduced alliance funding in 2025/26.
- An operational improvement plan was submitted to NHSE as part of alliance assurance.

Delivery

- C&M expects to meet the 75% and 85% ahead of England as a whole. There is almost no risk to the end of year trajectory position for 62d.

5. Exception Report – Cancer

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



Issue

- C&M not yet achieving the 96% 31-day combined standard required. However, the figure of 94.4% is 5th amongst Cancer Alliances and 17th amongst ICBs. It should be noted that this figure is ahead of England and represents good performance for C&M in relative terms.

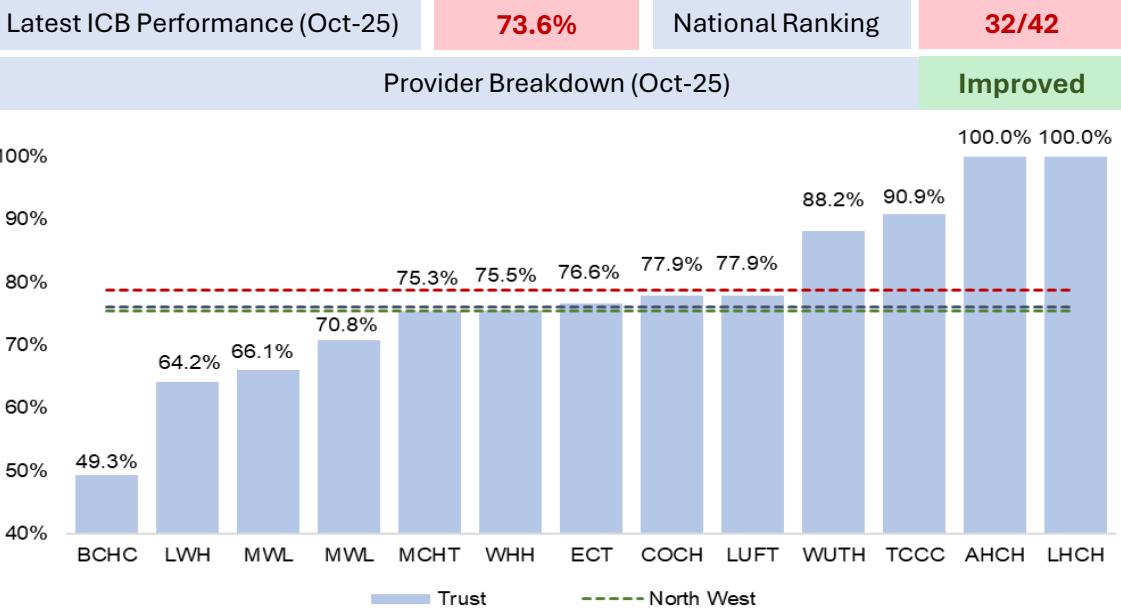
Action

- Providers not yet achieving the 31-day standard are surgical treatment providers.
- Capacity and demand exercises for 25/26 are addressing this and short-term investment is being made by the Cancer Alliance in key areas however, this is limited due to reduced alliance funding in 2025/26.
- An operational improvement plan was submitted to NHSE as part of alliance assurance.

Delivery

- C&M expects to meet the 96% ahead of England as a whole. Areas of 31-day breaches are identified and are targeted consistently with improvement plans.

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



Issue

- C&M Faster Diagnosis Standard (FDS) performance remains below the operational standard (77%, rising to 80% by March 26). This metric has improved this month and further in November (published) and December (forecast).

Action

- CMCA has produced bespoke improvement trajectories for each provider which are linked to improvement plans managed via the CMCA performance forum.
- The Pathways Improvement Programme continues to work across the nationally mandated priority tumour sites, implementing 'in depth reviews' to assess underlying performance drivers for cancer pathways (LGI, Breast, Skin, Gynae, Urology).
- A range of cross-cutting initiatives are underway such as an MDT bank, CDC optimisation group and single-queue diagnostic work.
- Skin has affected the FDS position seasonally and disproportionately due to system finance controls in part. MWL is exiting a recovery programme led by the alliance over 12 weeks which has recovered FDS performance. We expect a return to trajectory for the alliance in Q4.

Delivery

- C&M is still expecting to meet the 80% ambition by the end of the financial year 25/26.

5. Exception Report – Community

Community Services – Adults waiting over 52 weeks

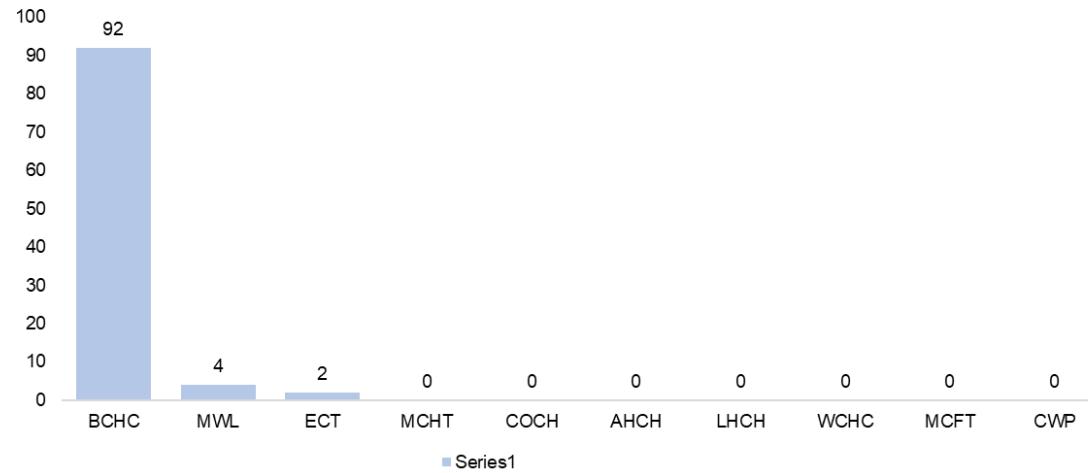
Latest ICB Performance (Oct-25)

410 *

National Ranking

n/a

Provider breakdown (Oct-25)

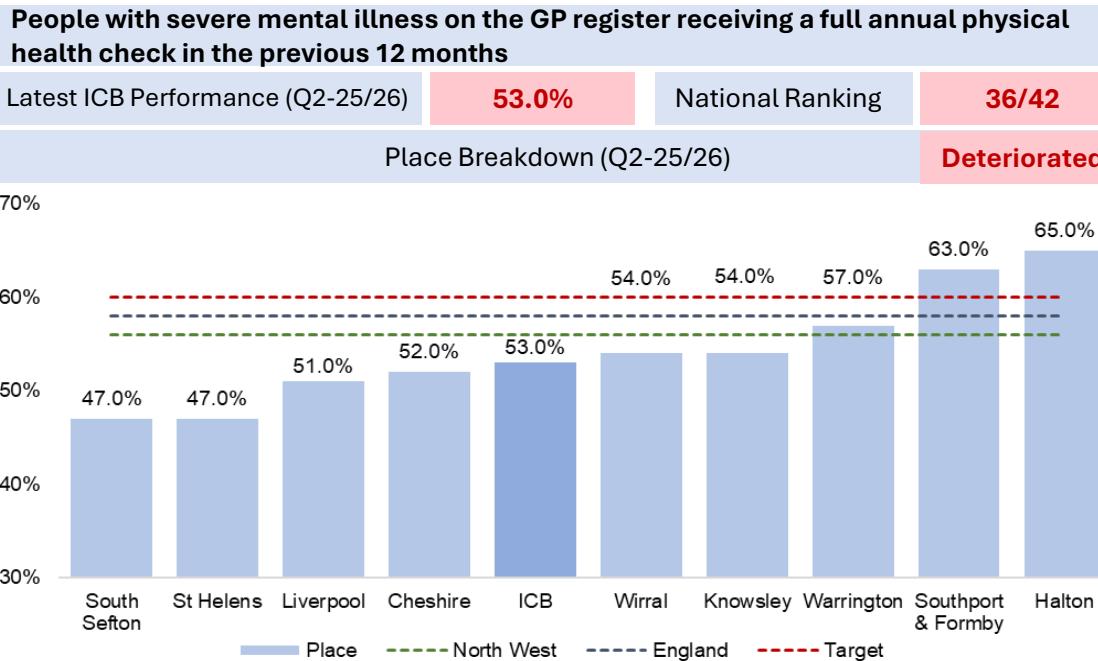


Issue/Action

- **BCHC Dermatology:** A recovery plan is in place to ensure all first-appointment waiters are under 52 weeks by the end of March 2025. The team is progressing at pace with weekly reviews of the waiting list, appointment optimisation, and DNA management. Consultant Connect is supporting review and validation of patients over 40 weeks.
- **BCHC Podiatry (Halton & Warrington):**
- **Halton:** As of M8, 47 patients are waiting over 52 weeks. Numbers have already reduced through criteria changes, with further reductions expected as the revised eligibility criteria are applied to recent referrals.
- **Warrington:** As of November, 41 patients are waiting over 52 weeks. Recruitment to vacancies is complete, new starters taking up posts in January 26.
- Recovery plans are in place for both Warrington and Halton to ensure all patients over 52 weeks will be seen by the end of the financial year

*ICB figure includes the provider HCRG who deliver services outside of C&M

5. Exception Report – Mental Health



Issue

- ICB performance has fallen below the minimum 60% target. National ambition is to work towards 75% of people with SMI receiving all 6 physical health checks.
- Metric has been removed from MH operational planning metrics for 2025/26 and QOF incentive for GP practices has also been removed for completion of all 6 health checks in the new GP contract. These changes will limit the ability to actively influence a further increase in performance.

Action

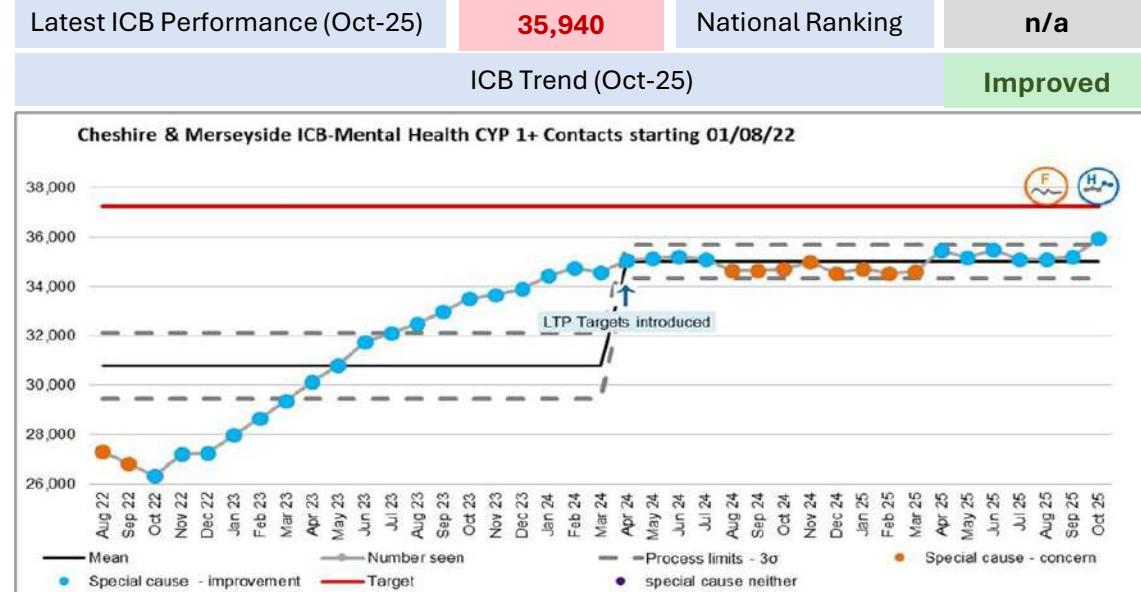
- Places to consider continuation of existing outreach schemes which promote and encourage uptake of physical health checks and note the risk of further adverse impact if serving notice.
- Consideration given to how monitoring of physical health in SMI will be incorporated in business-as-usual processes to satisfy requirements of the NHS Oversight Framework.

Delivery

- 6 of 9 places met the minimum 60% target in Q4 of 2024/25 but this has reduced to 3 places this quarter.
- Historic trends generally indicate below plan performance in the first 2 quarters of the year.

Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact

Latest ICB Performance (Oct-25)	35,940	National Ranking	n/a
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Issue

- There has been a 2% improvement in access, however rates remain circa 1,650 below target at 96% delivery of the LTP trajectory. Not all VCSE services are able to flow data to the national dataset so this activity is not captured in its totality, meaning the C&M position is understated.

Action

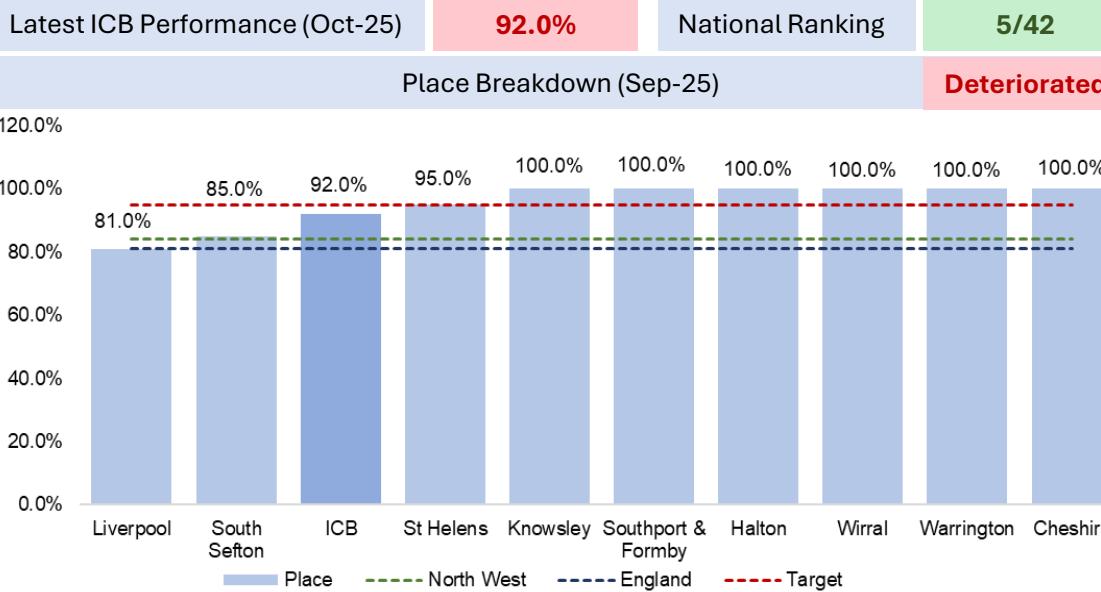
- A deep dive into activity undertaken by existing MH Support Teams in schools is progressing with a view to increasing access reported.
- Request made for “in-month access” report to be added to BIP as 12-month rolling activity can be misleading. Aim to identify in-month changes more quickly and address areas of concern.
- ICB place leads to develop a VCSE data improvement plan to address gaps in non-NHS funded activity, recognising digital and infrastructure variation across the sector.

Delivery

- There has been no significant change in overall C&M access rates since 2024, however there is more significant variance in place level trends.

5. Exception Report – Mental Health

CYP Eating Disorders Routine



Issue

- National data indicates a 1% deterioration in performance between Sep 25 and Oct 25 based on nationally published data. Local data is being reviewed as this has previously indicated that at least 95% of CYP are being seen within 4 weeks for routine appointments.
- Alder Hey performance has reduced from 91% to 87% between Sep and Oct 25. This is being validated.

Action

- MCFT have developed local 'live' reports to track the MHSDS data set as national reporting does not appear to be reflective of the local data.
- Work is underway to review how pathways can be improved across community eating disorder teams to provide more effective and efficient care.

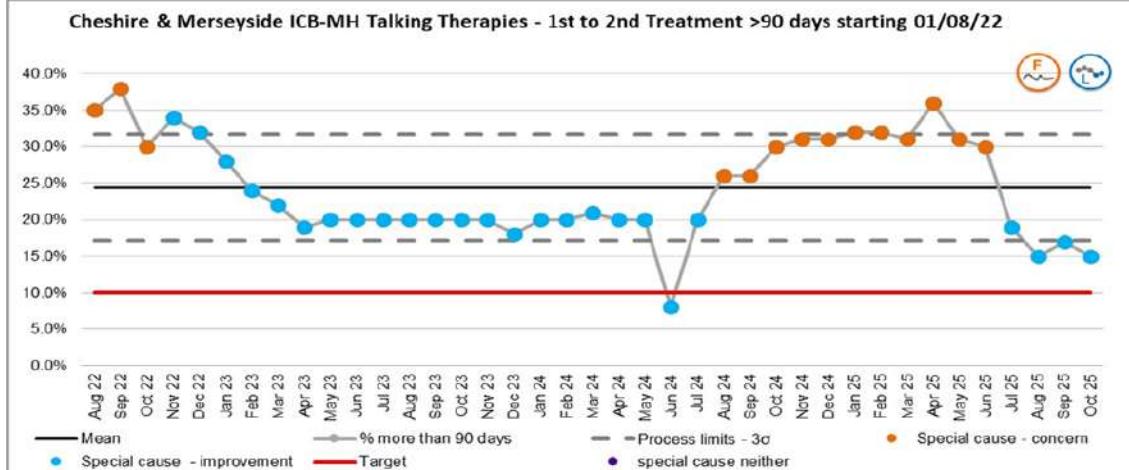
Delivery

- Alder Hey nationally reported data indicates that 87% of CYP are being seen within 4 weeks.
- CWP continues to achieve 100% of patients seen within 4 weeks.
- Mersey Care nationally reported data indicates 93% of CYP are seen within 4 weeks. This is a 6% increase compared with the previous month.

Talking Therapies 1st to 2nd Treatment >90 days

Latest ICB Performance (Oct-25)	15.0%	National Ranking	16/42
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ICB Trend (Oct-25)	Improved
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Issue

- The proportion of people who wait more than 90 days between 1st and 2nd treatment should not exceed 10%. Current ICB performance exceeds this, with nationally published data indicating delivery of 15%.
- Wirral Talking Therapy provider, Everyturn MH, has not submitted data following a system migration in Jul 2025 and this is impacting on the overall ICB position. Everyturn reported 32% of patients waiting >90 days in their Jun 25 submission.

Action

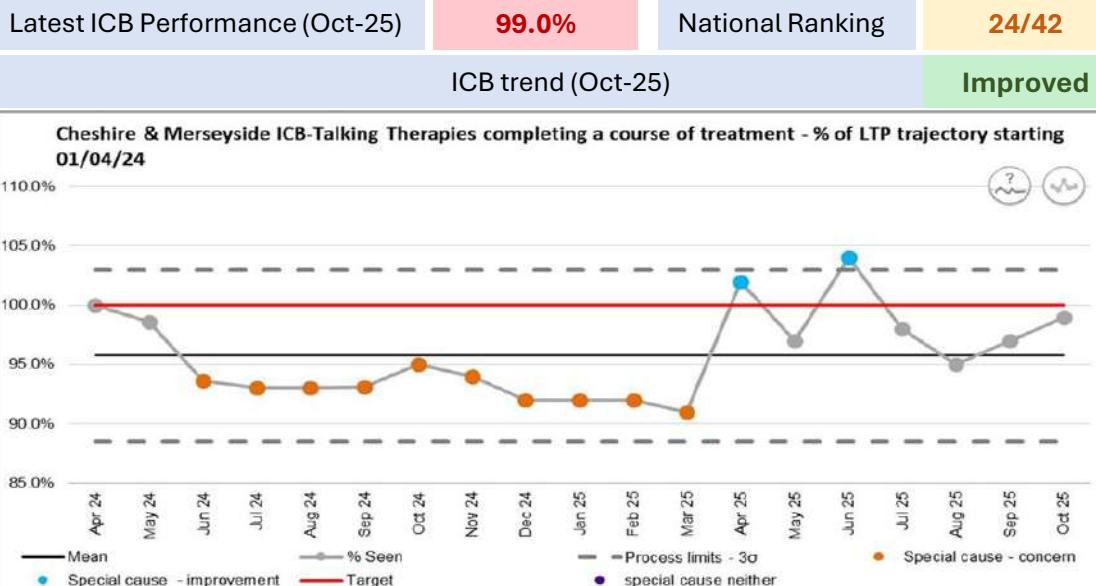
- Wirral data submissions have recommenced, however, waiting times are not currently included
- Group or e-therapy first model being implemented – with staggered starts to groups to create less wait time for a course to start
- Review of waiting lists and reduction in waiting times
- Greater engagement with data which supports providers with insights into areas for improvement within their services

Delivery

- The percentage of people waiting >90 days between treatment varies between 39% and 8% across Cheshire and Merseyside's 5 local providers
- At place level variances are between 39% in Warrington & Sefton and 2% in Liverpool

5. Exception Report – Mental Health

Talking Therapies completing a course of treatment - % of plan achieved



Issue

- National reporting indicates that the number of people completing a course of treatment has increased by 2% since the previous month.

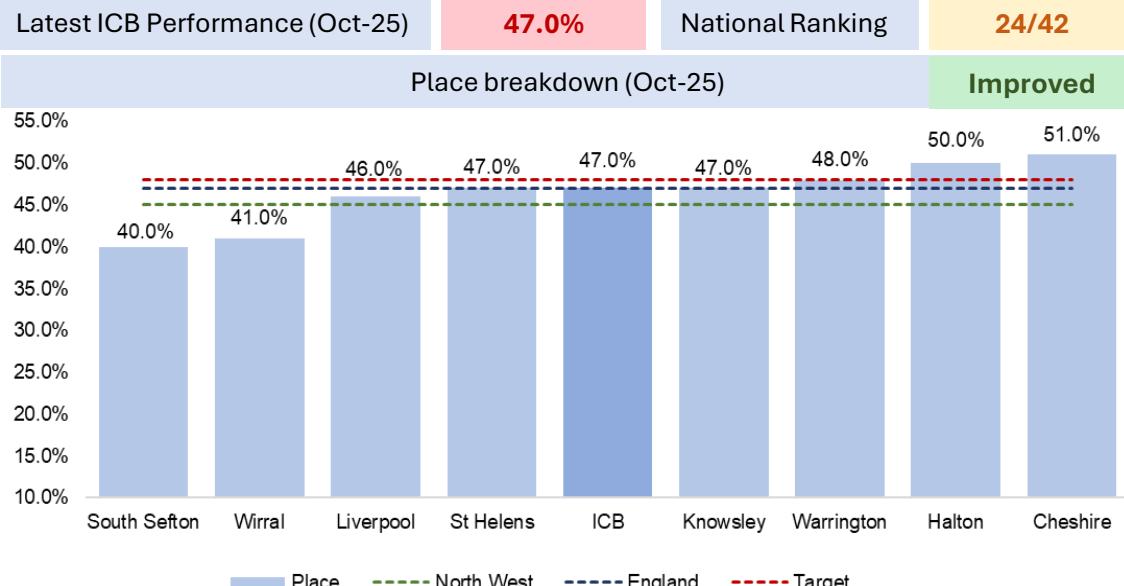
Action

- Workforce expansion is underway aligned with additional funding committed for a 5-year period.
- Additional trainee therapists have started in post and attraction and recruitment of additional qualified therapists from outside of Talking Therapy services is progressing.
- A “readiness for therapy” video has been developed to minimise the number of people not completing their course of treatment.
- Work continues to interrogate Talking Therapies data and look at areas that impact on productivity such as DNA rates, contact hours etc to inform service improvement plans.

Delivery

- Trajectories have been set at place level and shared with each of C&M’s five talking therapy providers and activity will be monitored at this level.

Talking Therapies Reliable Recovery



Issue

- Nationally reported data indicates that reliable recovery rates have increased to 47% this month against a target of 50%. However, Wirral Talking Therapy provider, Everyturn MH, has recently migrated to a new system and did not submit data in July and Aug. Sep and Oct. Reliable recovery reported for Wirral is lower than anticipated and this is impacting on the overall ICB rates.

Action

- Wirral data submissions have resumed following system migration.
- National workforce modelling tool has recently been published and will facilitate staffing review. Planning to rebalance the ratio of low intensity to high intensity therapists to improve reliable recovery and reliable improvement rates, aligned with national guidance.
- Increased workforce will facilitate increased session numbers to improve reliable recovery and work towards national ambition of 53% reliable recovery by 2028/29.

Delivery

- Cheshire and Halton places have achieved reliable recovery targets for Oct 25.

5. Exception Report – Learning Disabilities

Adult inpatients with a learning disability and/or autism

Latest ICB Performance (Nov-25)

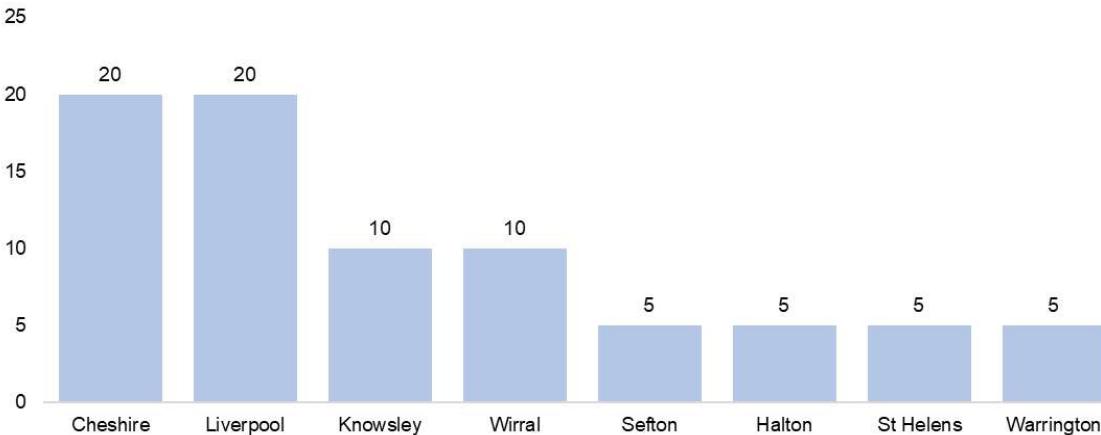
75 *

National Ranking

16/42

Place Breakdown * (Nov-25)

No change



Issue

- There were 80 adult inpatients, of which 45 are NHSE Specialised Commissioning (Spec Comm), and 35 ICB commissioned. The target for C&M (ICB and Spec Comm) is 46 LD/A or fewer by the end of Q4 2026.

Action

- The Transforming Care Partnership (TCP) has scrutinised those clinically ready for discharge. Of those 80 adults, 13 individuals are currently on Section 17 Leave. It is expected that some of the existing section 17 leave individuals will be discharged in Q4 pending MOJ Clearance and transition progress. 26 people have been discharged since April 2025.
- Data quality checks continue to be completed on Assuring Transformation to ensure accuracy.
- 2-weekly C&M system calls ongoing to address Delayed Discharges with Mersey Care and CWP.
- Housing Lead continues to work to find voids which can accommodate delayed discharges.
- Desktop reviews to address section 17 leave progress and those identified for discharge.
- Transforming Care Lead is linking into Provider MADE calls.
- The decommissioning of Alderley Unit will mean further discharges in Q3 and Q4.

Delivery

- C&M ICB and NHSE aim to reduce the number of inpatients, where appropriate, by the end of Q4 2025/26, where the target is 46 for LD/A and 28 for people with Autism. A variance of 12 in ASC now.
- C&M ICB have moved from the 4th quartile to the 2nd quartile in performance, being 1 of only 18 who have achieved the inpatient rate of 37 inpatients per million population.

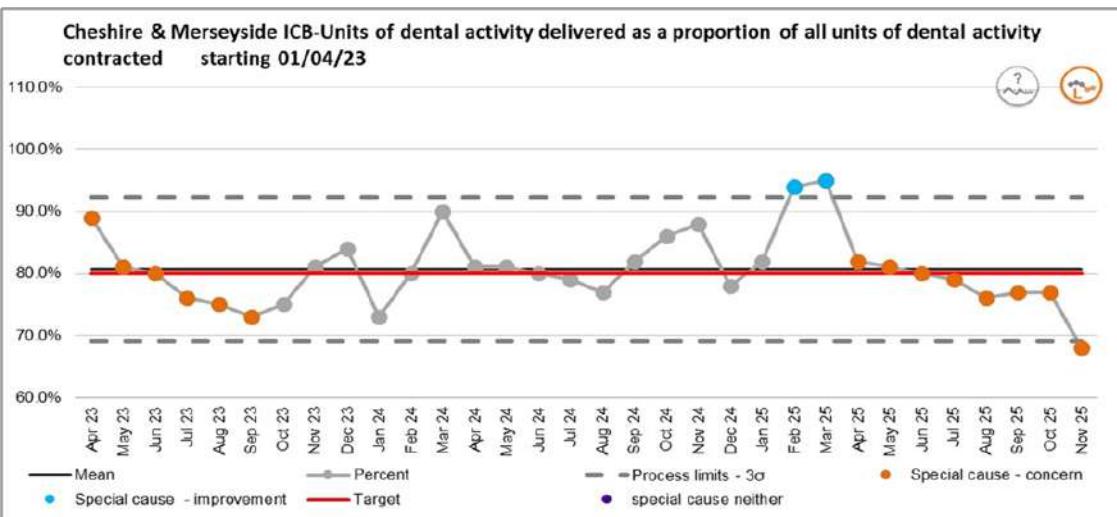
* Data rounded up/down to nearest 5: therefore, Place subtotals may not add up to the ICB total

5. Exception Report – Primary Care

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

Latest ICB Performance (Nov-25) **68.0%** National Ranking **33/42**

ICB Trend (Nov-25) **Deteriorated**



Issue

- C&M does not currently meet the 80% target.

Action

- Local Dental Improvement Plan 25/26 implementation has been focusing on access and includes actions being taken to increase activity relating to routine access and urgent care linked to national urgent care scheme and C&M share (46k) of the national 700k appts target.

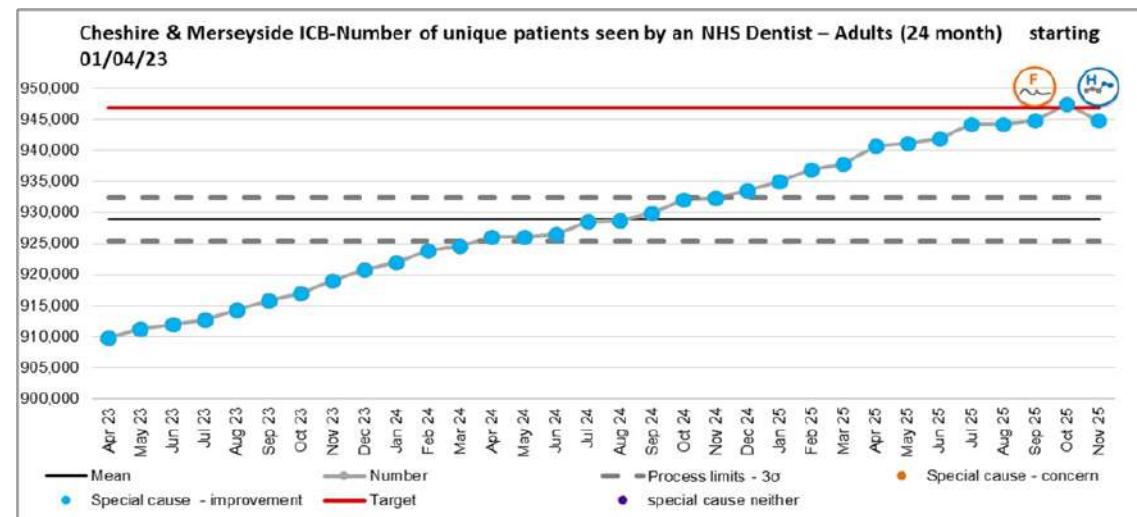
Delivery

- Fluctuations in delivery of target are expected throughout the year such is the nature of national contract.

Number of unique patients seen by an NHS Dentist – Adults (24 month)

Latest ICB Performance (Nov-25) **944,820** National Ranking **n/a**

ICB Trend (Nov-25) **Deteriorated**



Issue

- C&M is currently below target.

Action

- Continue to support network of providers to see new patients who require an NHS dentist delivering Pathway 1/2/3 in local dental plan 25/26.
- Working with providers to ensure accurate and timely submission of data to BSA.
- Rapid evaluation of unscheduled care completed and now been evaluated by commissioners for 26/27 planning purposes.

Delivery

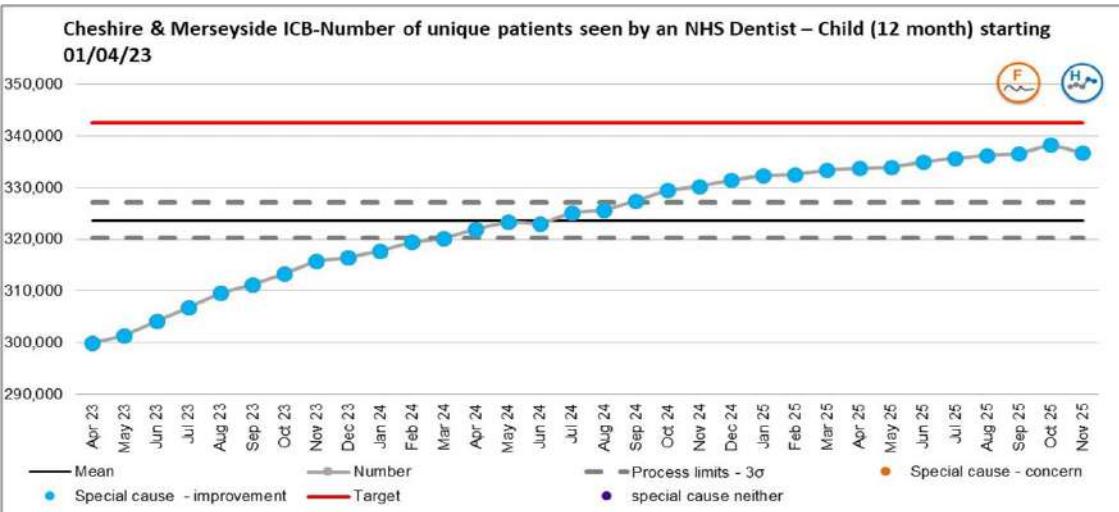
- Commissioners are using flexible commissioning arrangements to improve activity and working with national team to understand 26/27 contract reforms.

5. Exception Report – Primary Care

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

Latest ICB Performance (Nov-25) **336,705** National Ranking n/a

ICB Trend (Nov-25) **Deteriorated**



Issue

- C&M is currently below target .

Action

- Continue to support network of providers to see new patients who require an NHS dentist delivering Pathway 1/2/3 in local dental plan 25/26.
- Working with providers to ensure accurate and timely submission of data to BSA.
- Rapid evaluation of unscheduled care completed and now been evaluated by commissioners for 26/27 planning purposes.

Delivery

- Commissioners are using flexible commissioning arrangements to improve activity and working with national team to understand 26/27 contract reforms.

Total volume of antibiotic prescribing in primary care

Latest ICB Performance (Sept-25) **0.92** National Ranking n/a

Place breakdown (Sept-25) **Improved**



Issue

- C&M does not currently meet the target set for the volume of prescribing of antibiotics although performance continues to improve.

Action

- All Places continue the cascade of education, public communication work, reviewing prescribing data and decisions in relation to antibiotic prescribing.
- Recruitment underway for two AMR Consultant Pharmacists to lead system-level AMS work.
- NHS England letter shared a letter in November 2025 asking for a call for urgent action regarding AMR, including board-level review and executive oversight, risk and capability assessment, set and publish 3 AMR improvement priorities by April 2026.
- There are plans to include a single AMR element across all place incentive schemes for 26/27. Draft options include:
 - Option 1 - Reduction in total antibiotics/ STAR PU
 - Option 2 - Practice AMS Activities
 - Option 3 - Increase 5/7 course lengths of amoxicillin and doxycycline
 - Option 4 - A Focus on Children Prescribed Antibiotics in Primary Care

Delivery

- Analysis to continue with Q3 2025/26 data at Place and ICB level to inform areas to focus on at Place and C&M level.

5. Exception Report – Specialised Commissioning

Neurosurgery waiting list (TWC)

Latest ICB Performance (Oct-25)

1,023

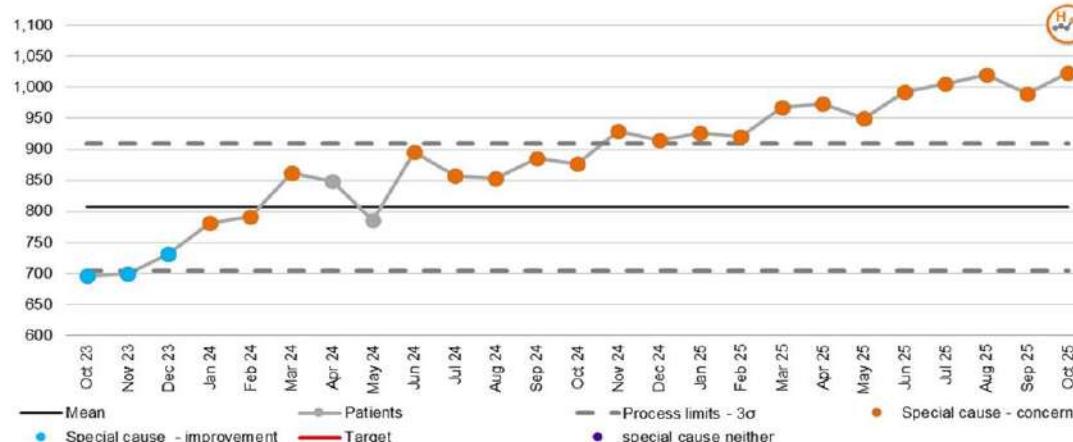
National Ranking

n/a

ICB Trend (Oct-25)

Deteriorated

Cheshire & Merseyside ICB-Specialised Commissioning - Neurosurgery - TWC starting 01/10/23



Issue

- The waiting list for Neurosurgery at The Walton Centre has been steadily increasing and the current number is greater than the same period last year.

Action

- The Trust have been undertaking a programme of theatre refurbishment works for a large part of this year which means that their theatre capacity has been reduced by 15%. Works are expected to be completed in January.
- Referral rates have increased significantly so work has commenced to strengthen the community MCAT service through virtual MDTs as it is believed that a lot of referrals are reaching the tertiary provider unnecessarily.
- Walton continue to be affected by the ICB cap on bank rates and this has resulted in some cancellations through impact upon critical care workforce capacity. The Trust are actively trying to fill these vacancies and hope to be fully established by the end of March.

Vascular waiting list (LUFT)

Latest ICB Performance (Oct-25)

176

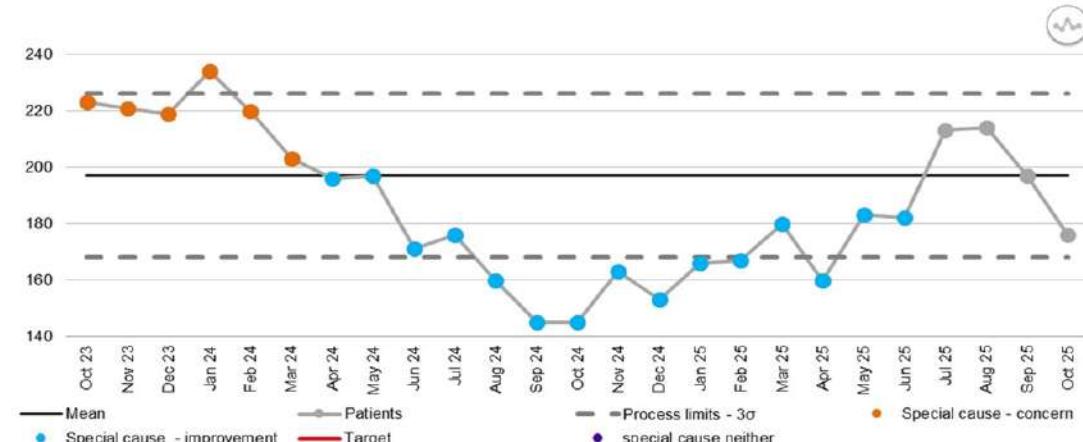
National Ranking

n/a

ICB Trend (Oct-25)

Improved

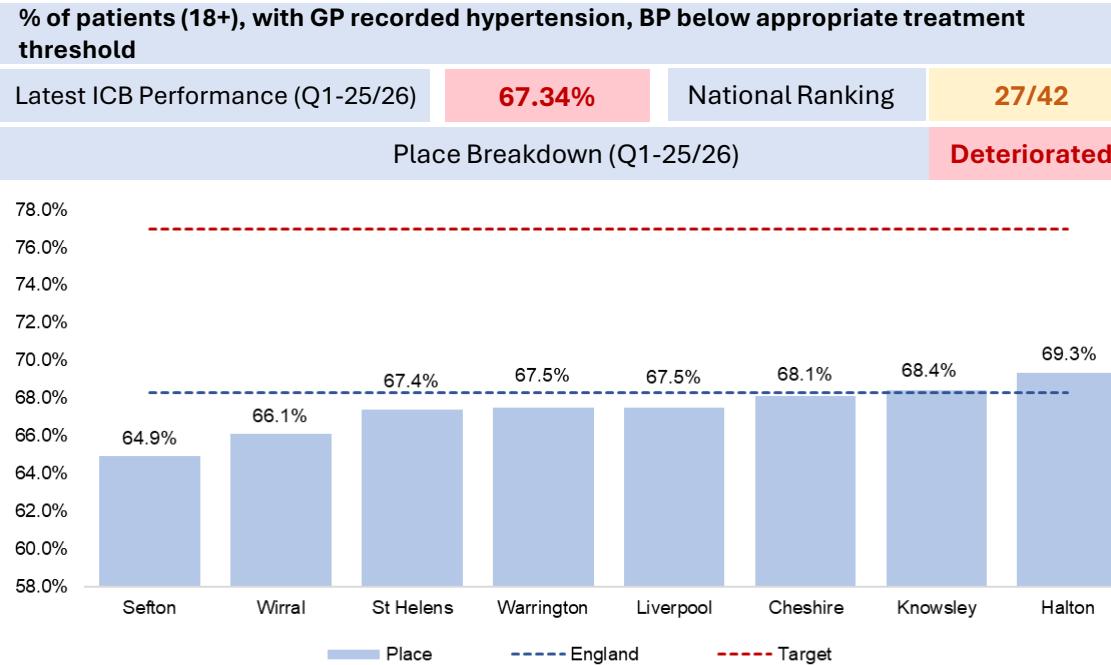
Cheshire & Merseyside ICB-Specialised Commissioning - Vascular - LUFT starting 01/10/23



Issue

- Upon further investigation, the vast majority of these waits are incorrectly coded, and are actually awaiting varicose vein treatment which is ICB funded.
- Historically, vascular coded activity funded by Spec Comm is very minor. This will be investigated further.

5. Exception Report – Health Inequalities & Improvement



Issue

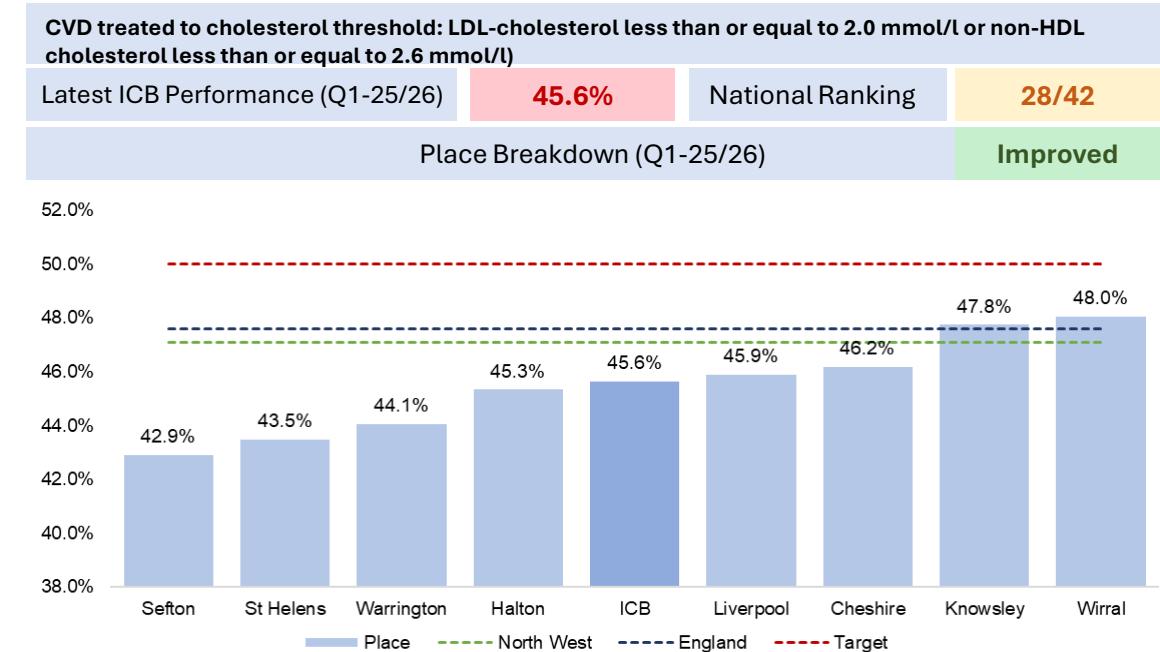
- There is deterioration this quarter (mirrored by the England trend) and there remains considerable variation between Places. C&M does not currently meet the national target ambition

Action

- The hypertension case finding in optometry pilot continues with 60 opticians and representation from each Place. Over 1000 readings taken with 500 more planned before the project is complete and evaluation can begin. The national evaluation is due to be shared before the end of Q3
- Cycle 2 of the CLEAR programme almost complete. Work to start with the last Cycle in Q3, with a further 6 PCNs adopting a new model of care re: CVDP which may include hypertension.
- Health Inequalities BP optimisation project complete and evaluation shared widely; additional Clinical Pharmacist time secured to lead on development and dissemination of recommendations.
- There has been a successful Know Your Numbers BP awareness Campaign co-ordinated across multiple organisations incl. opportunistic BP testing pop ups in community settings.
- EOI submitted to NHSE to become a CVD Prevention Accelerator Site with a focus on BP.
- ‘Prevent it, Detect it, Treat it’ will target all parts of the BP pathway. Awaiting bid outcome

Delivery

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



Issue

- This is a new metric reported this quarter, that aligns with the planning guidance to target established CVD cholesterol management. Considerable variation exists between Places and between ICBs. There isn't currently a national target ambition for this metric.

Action

- Clinically led C&M Lipid Management group leads this work. A mapping exercise is being undertaken to understand the barriers and opportunities in both primary and secondary care to improve care and outcomes related to secondary prevention lipid management.
- Continued development of a suite of user-friendly resources and educational opportunities for primary care colleagues to better support Lipid management. The second in a series of webinars is planned for November, and the patient toolkit is due to be reviewed by the Clinical Effectiveness Group before launching in Q3.
- Cycle 2 of the CLEAR programme is nearing completion. Work will start with the last Cycle in Q3, with a further 6 PCNs to adopt a new model of care around their chosen aspect of CVD prevention which may include Lipid management.

Delivery

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

5. Exception Report – Health Inequalities & Improvement

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

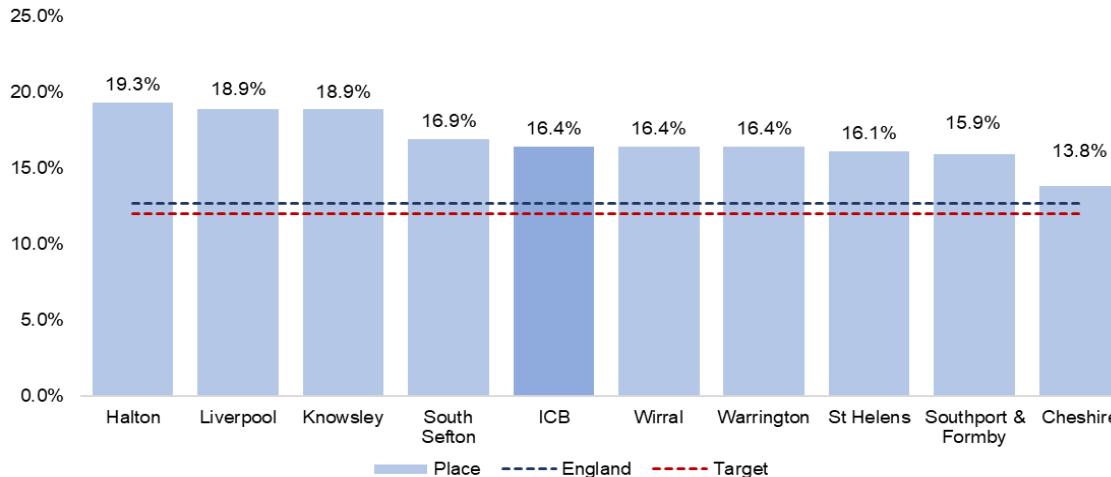
Latest ICB Performance (Nov-25)

16.4% *

National Ranking

n/a

Place Breakdown (Nov-25)



Issue

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

Action

- Work is progressing on the review of the smoking cessation system in C&M to ensure we are optimising service capacity to support smokers to quit.
- Exploratory meetings have taken place with two NHS Trusts to explore implementing opt-out smoking cessation interventions in pre-op departments.
- The [What Will You Miss](#) communication campaign has been launched in January encouraging smokers in Cheshire and Merseyside to think about the key milestone life events they could miss out on if they continue to smoke.

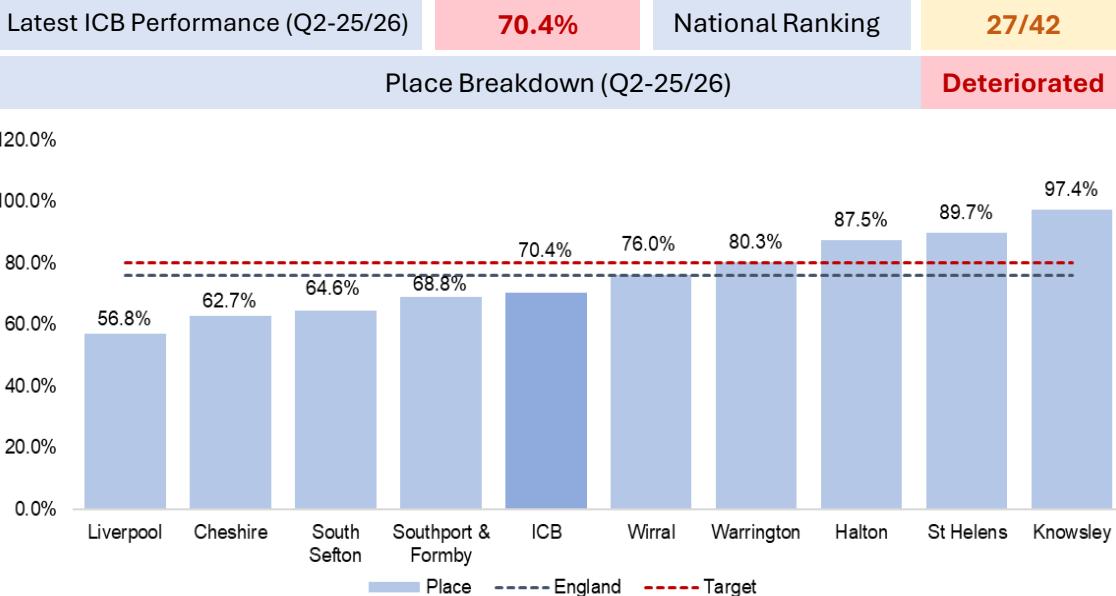
Delivery

- Supporting smokers to access specialist smoking cessation services to support them to quit should remain a key priority for all staff working in the NHS.

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

5. Exception Report – Continuing Healthcare

Standard Referrals completed within 28 days



Issue

- Cheshire and Merseyside ICB is not currently meeting the NHS England KPI for Standard CHC referrals to be completed within 28 days. The target is 80%.

Action

- A review of AACC delivery across C&M has taken place to develop a single structure and improve consistency and capacity across the 9 sub-locations. This included the in-housing of Liverpool and Sefton place-based teams, which remain the main outliers for this metric.
- Cheshire East and West report a deteriorating position with performance due to the number of voids in the team (vacancy freeze/ staff absence/SW vacancies).
- Additional scrutiny of the AACC delivery is in place via monthly Place Assurance Meetings.

Delivery

- The ICB delivery was within the quarterly trajectory agreed with NHS England for Q2. The projection was $\geq 70\%$ to 74.9%.

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



Issue

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

Action

- NHS C&M ICB are producing a suite of supportive policies and procedures to support teams in delivering consistent delivery and application of NHS CHC across the C&M system. Some are already operational and published whilst others are in various stages of ratification and development.

Delivery

- A Fast Track pilot in South Sefton is showing positive results and is planned to be rolled out for further testing in North Sefton. A formal update will be taken to Place Assurance in December.
- There is an overall improved position for this metric within C&M.

*snapshot at end of quarter

5. Exception Report – Continuing Healthcare

Number eligible for standard CHC per 50,000 population *

Latest ICB Performance (Q2-25/26)

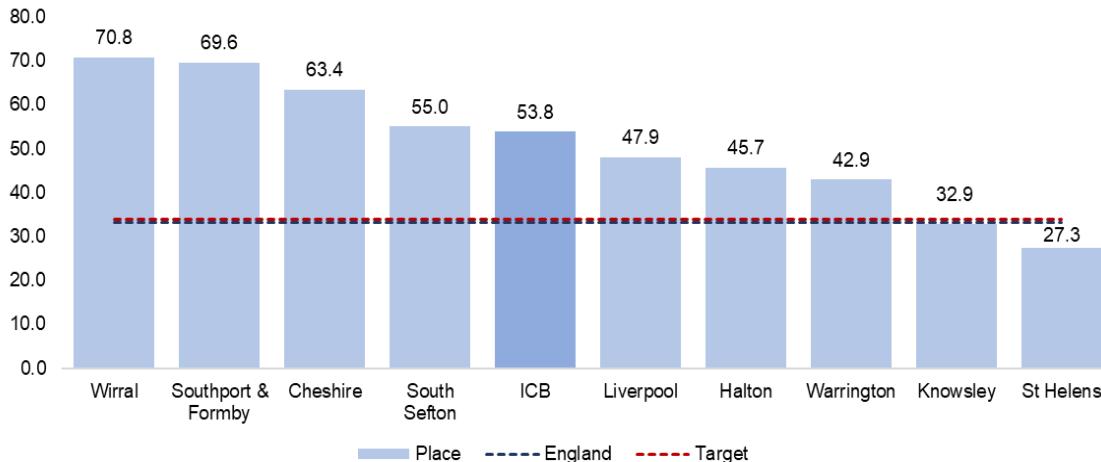
53.8

National Ranking

40/42

Place Breakdown (Q2-25/26)

Deteriorated



Issue

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

Action

- The main outliers for this metric are Wirral, Southport and Formby, Cheshire and Sefton. Sefton, Southport and Formby are still recently in-housed teams and some positive action has been seen within other metrics. Additional contract meetings are being held with the outsourced service in Wirral.

Delivery

- Delivery is anticipated to improve through a consistent application of processes noting the historic and ongoing impact of formerly outsourced teams; any change would not be rapid due to the CHC processes. (Figures may also be impacted by demographics.)

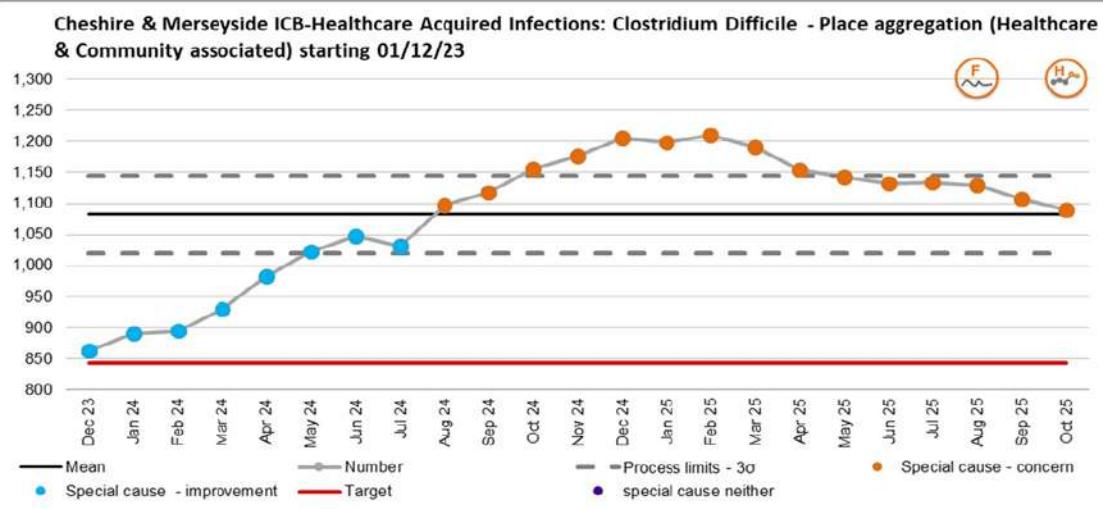
*snapshot at end of quarter

5. Exception Report – Quality

HCAI: Clostridium Difficile - Place aggregation (Healthcare & Community associated)

Latest ICB Performance (12 months to Oct-25) **1,090** National Ranking **n/a**

ICB Trend (rolling 12 months to Oct-25) **Improved**



Issue

- The C&M rate of CDI has continued to show an improvement. There continues to be a high outlier alert for WUTH based on Q2 data and for both WUTH and COCH based on 12-month data. The overall Q2 position for both providers observes a reducing rate. Whilst not an outlier AHCH had seen an increasing rate of infection but with no cases in October and November may be improving.
- The C&M rate of E. Coli has improved in October but increased again in November showing no sustained improvements. LUFT remains a high outlier in both Q2 and 12-month data with minimal change in rate, the C&M position has been supported by significant reductions in rates at COCH, who are now noted as a low outlier. In addition to LUFT, CCC has a high rate of infection and is noted as a high outlier in the 12-month data.

Action

- The implementation and monitoring of the CDI tool kit continues to be a priority, alongside local improvement plans at WUTH and COCH. The emerging concerns at AHCH have seen initial support from UKHSA and will be followed up by a meeting between the provider, ICB, NHSE and UKHSA to discuss any action required.
- The progress of the improvement plan at LUFT continues to be a focus at quality contract discussions.

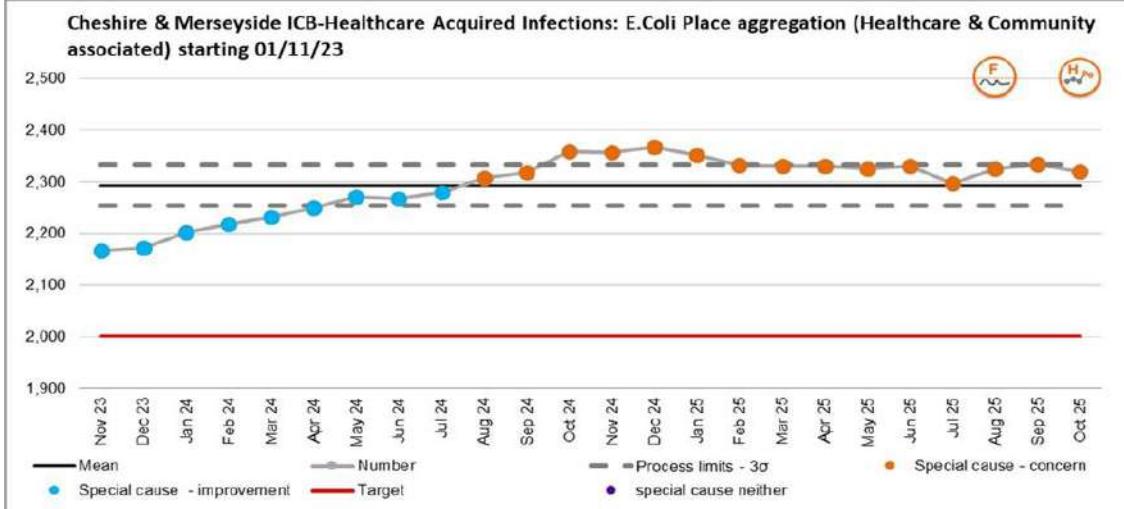
Delivery

- The ICB tolerance for both CDI and E. Coli remains at risk with Q2 rates exceeding 50% of annual tolerance and early indications suggesting that any reductions in Q3 are not sufficient to alter this course. CDI tolerances have breached annual tolerance at month 8 at AHCH, ECT, LHCH, CCC, TWC and LWH. E. Coli tolerances have breached at CCC and TWC.

HCAI: E.Coli Place aggregation (Healthcare & Community associated)

Latest ICB Performance (12 months to Oct-25) **2,320** National Ranking **n/a**

ICB Trend (rolling 12 months to Oct-25) **Improved**



5. Exception Report – Quality

Never Events

Latest ICB Performance (Nov-25)

2

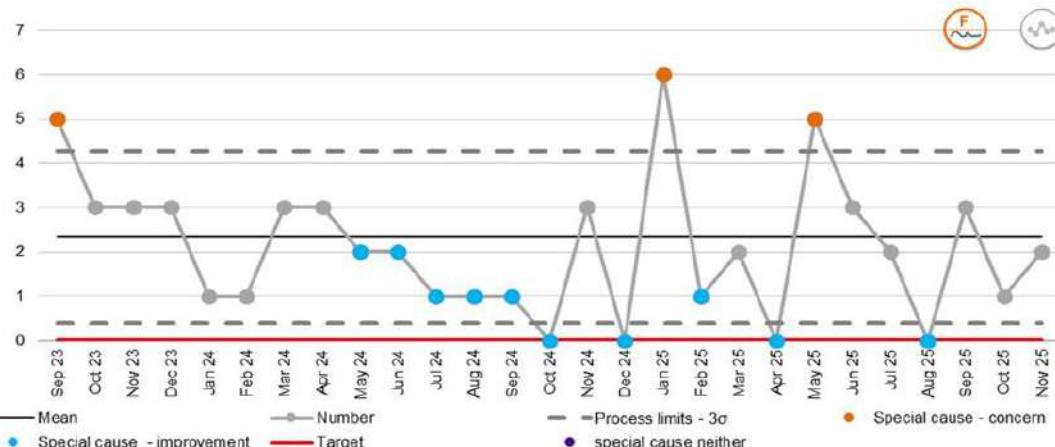
National Ranking

n/a

ICB Trend (Nov-25)

Deteriorated

Cheshire & Merseyside ICB-Never Events starting 01/09/23



Issue

- C&M continues to see an increase in Never Events across the system with 2 reported in November. The rolling 12 month position at 25 cases has seen an increase during the year.
- Both Never Events in November were related to surgical safety.
- There are 3 trusts standing out following clusters of cases; AHCH, WHH and WUTH. MWL is also being observed closely for assurance, no clusters but general high rate of cases.

Action

- There are thematic reviews taking place at the three identified providers.
- The ICB is conducting a deep dive into surgical safety procedure assurance received from each trust across C&M and reporting back to QPC.
- The review is intended to describe priority improvements and trajectories to monitor across all surgical providers.

Delivery

- Current rates are deteriorating.

5. Exception Report – Quality

Summary Hospital-level Mortality Indicator (SHMI)

Latest ICB Performance (July-25)

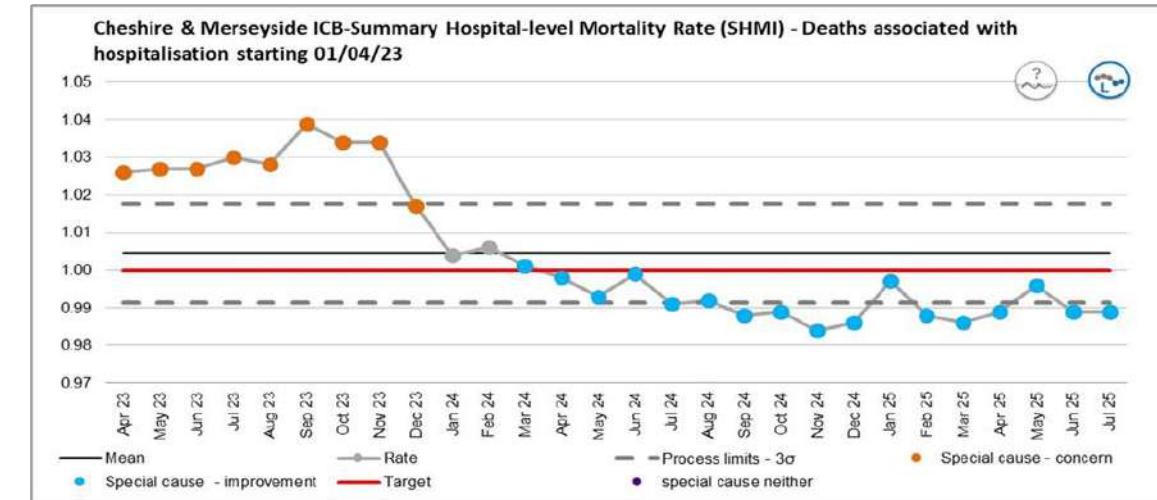
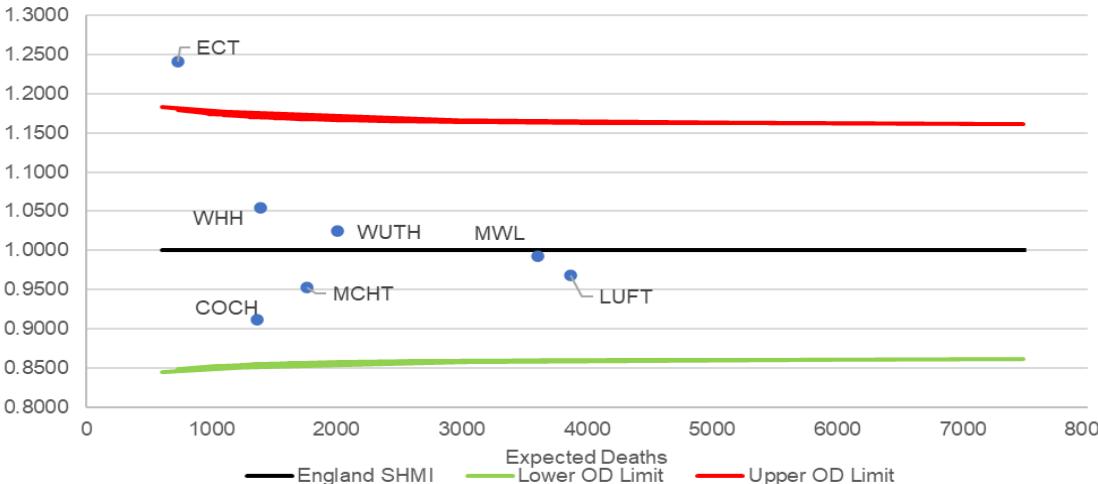
0.989

National Ranking

n/a

Provider Breakdown (July-25)*

No change



Issue

- C&M trusts are within expected tolerances except ECT, with a current value of 1.2226 against the upper control limit for ECT of 1.1794.

Action (ECT only)

- The trust has moved to quality improvement phase of quality governance/escalation.
- Scrutiny continues between the ICB and trust in board-to-board meetings and system oversight reviews ensuring the optimal support is in place to bring about best patient outcomes.
- Over the last 2 months reporting has been impacted by data quality issues reported to be associated with the launch of a new electronic patient record. Furthermore, activity has been reported to have been reduced to supported go-live of EPR which will further influence SHMI calculations as low risk elective work is diminished.

Delivery

- SHMI for ECT had moved to the upper confidence interval for the first time since July 2022 in July 2025 but has now deteriorated.
- The improvement culture in the trust is palpably improved and since the Board to Board review has led to next steps including a review using HSMR+ that has demonstrated a significantly frail elderly population and clear improvement in mortality when measured using the HSMR+ methodology. It is also inside the 95% confidence interval on a funnel plot and RAMI is in normal range. Proportionately more patients die out of hospital than might be expected. The trust is being asked for detail behind this observation, that may reflect preferred place of death being delivered. Detail on palliative care coding has been requested.

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

5. Exception Report – HR/Workforce

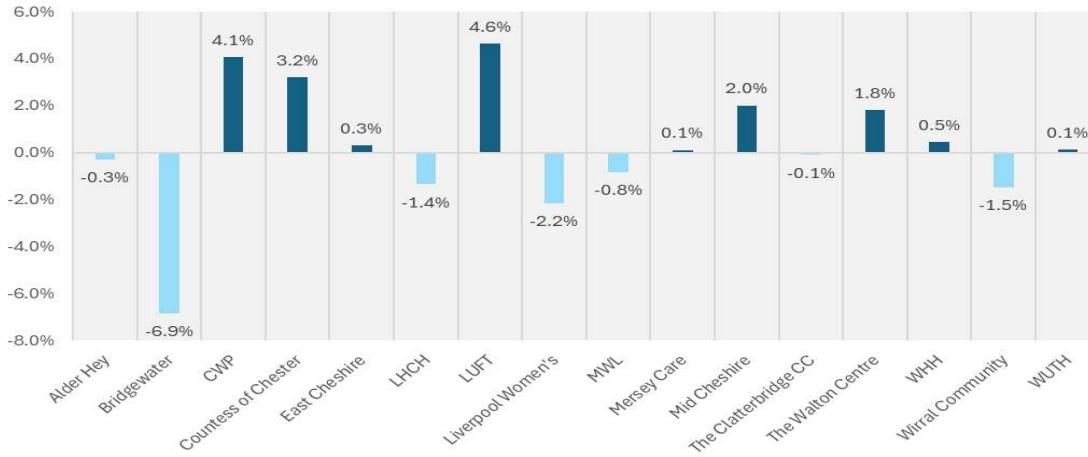
Total SiP (Substantive + Bank+ Agency) Variance from Plan % - via PFRs

C&M ICB Performance (Nov-25)

1.1%

Provider Breakdown (Nov-25)

Total Workforce - % Variance from Plan Nov-25



Substantive Variance from Plan % - via PFRs

C&M ICB Performance (Nov-25)

1.2%

Provider Breakdown (Nov-25)

Substantive - % Variance from Plan Nov-25



Issue

- In Nov-25, nine of the sixteen C&M Trusts reported their total workforce WTEs were above their planned figure as at M08, with a C&M variance above plan of 1.1% (889.6 WTE) versus 592 WTE (0.7%) higher than plan last month. These variances are based on the 2025/26 Workforce Operational Plan submissions with monthly forecasts for WTE for 25/26 as submitted to NHS England. Provider WTE run rate has been static over the last 5 months with overall pay higher than plan – with Industrial Action in M4 & M8..
- Ten of sixteen C&M Trusts reported substantive staff in post numbers higher than that forecast in their operational workforce plans. The total system performance was a variance from plan of 1.2%. At a system level, substantive staff utilisation decreased by 73.8 WTE / 0.1% from the previous month.

Action

- NHS C&M monitoring & acceleration of the workforce action plans has been initiated – with a key focus on productivity & efficiency opportunities in temporary staffing (Bank & Agency) & corporate services/enabling functions. NHS C&M is supporting Trusts with their workforce (WTE), activity & finance (pay bill) triangulation through CIP (Cost Improvement Plan) monitoring.
- Greater scrutiny of workforce and pay costs data at organisational and system level is now taking place. The workforce WTE monitoring dashboard is shared with Trusts monthly – for review and feedback; where individual performance can be interrogated in terms of WTE numbers & assumptions for the coming quarter / financial year, and impact on specific professional groups in service pathways.

Delivery

- Workforce workstreams for Sustainable Nursing Workforce Changes & Medical Workforce Changes continue to report into system FCOG – Financial Control & Oversight Group – for C&M NHS Trusts.

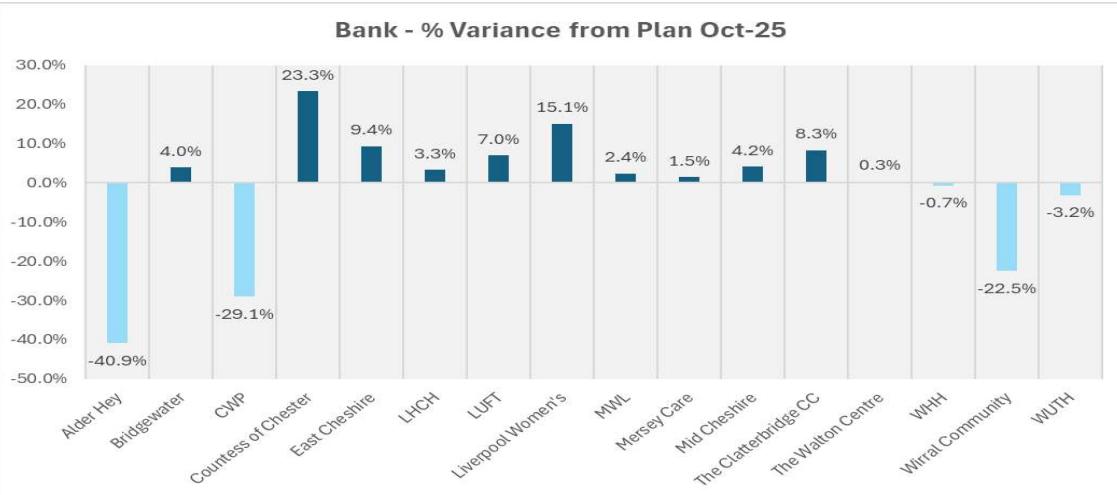
5. Exception Report – HR/Workforce

Bank Variance from Plan % - via PFR

C&M ICB Performance (Nov-25)

5.1%

Provider Breakdown (Nov-25)



Issue

- Eleven of sixteen C&M Trusts had Bank usage higher than that forecast in their operational workforce plans for the month of Nov-25. The total system performance was a variance from plan of 5.1% / 221.2 WTE.
- At a system level, the total bank usage decreased by -28.5 WTE / -0.6% from the previous month. Bank spend of £26.7m in month (across all C&M Trust Providers) – higher than 25/26 average of £24.5m (Industrial Action impact in month 8) & remains above plan & NHS Ceiling.

Action

- All Trusts are reviewing their internal workforce resourcing processes & specific organisational actions around temporary staffing data, premium staffing costs (WTEs Utilised and Rates Charged) & cross-checks between financial & workforce returns, which continues to be a focus for all Trusts, as part of the 25/26 planning process & financial recovery.
- Bank rates / cost of temporary staffing is currently being reviewed through FCOG workstreams alongside agency & locum rates to ensure consistency across the system.

Delivery

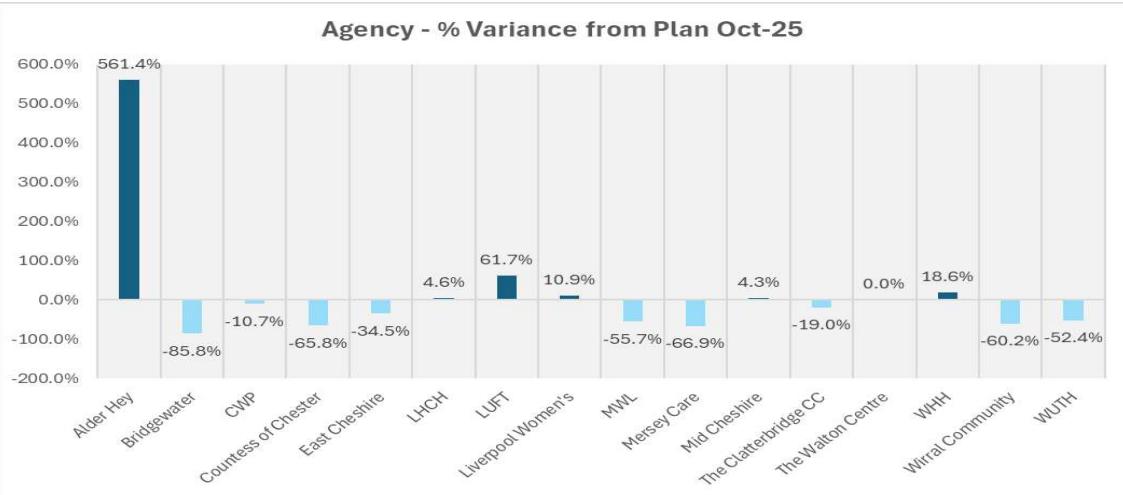
- Proactive monitoring of workforce / pay cost data & proposed actions/controls for the coming quarter with Chief People Officers C&M Provider Collaborative & CPO Network focussed workstreams.

Agency Variance from Plan % - via PFR

C&M ICB Performance (Nov-25)

-35.0%

Provider Breakdown (Nov-25)



Issue

- Nine of sixteen C&M Trusts had Agency usage lower than that forecast in their operational workforce plans for the month of November. The total system performance was a variance from plan of -35% / -225.9 WTE
- At system level, Agency usage reduced by -28.5 WTE / -0.6% from the previous month; this is -859.6 WTE from the Mar-25 baseline Agency £4.4m in month – lowest month in last 12mths – and below plan (£1.7m YTD) and below NHSE Ceiling

To note: small numbers/WTE for Planned v Agency usage at Alder Hey are skewing % change figures but are still above plan.

Action

- Temporary staffing data (Agency Spend & Off Framework Usage) is being reviewed across all Trusts in C&M – in line with their 25/26 Operational Plan submissions & assumptions..

Delivery

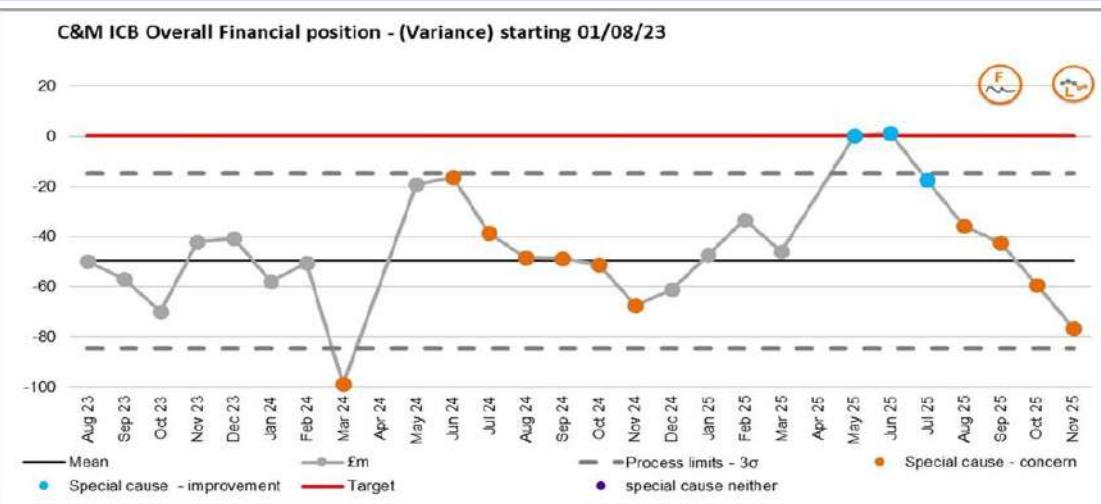
- Proactive communication to Chief People Officers, Workforce & Resourcing Teams about Off-Framework and Agency Spend data (by staff group) is shared monthly with additional input provided by NHSE North West.

5. Exception Report – Finance

Overall Financial position - YTD Surplus / (Deficit) (£m) - (including deficit support funding)

Latest ICS Performance (Nov-25) **-76.7** National Ranking n/a

ICS Trend (Nov-25)



Issue

- System reported deficit of £159m against a year-to-date deficit plan of £82m as at M8 (ICB - £33m surplus, providers £192m deficit). This is an adverse system variance of £77m.
- The reported YTD position includes the negative impact of the system not being in receipt of deficit support funding (DSF) for months 4-8, which has an adverse YTD impact of £74m on provider plans.
- DSF has been withheld by NHS England for Q2 and now Q3 due to concerns over the deliverability of financial plans. The system continues to forecast on the assumption that 100% of DSF will be provided and the withheld element retrospectively issued.
- Total deficit support funding assumed in the 2025/26 plans is £178.3m. Only Q1 (£44.6m) has been issued to date.
- Achievement of DSF will rely on the system fully delivering its efficiency plans and mitigating any unplanned pressures which is a significant risk at this stage.

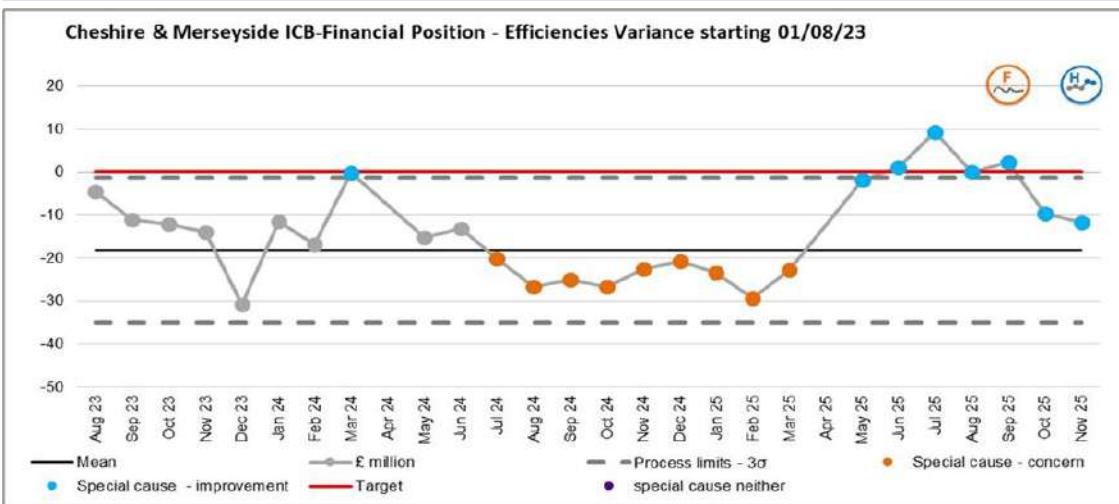
Action

- PwC and Simon Worthington are working alongside the region and ICB to assist delivery.
- Activity management plans being implemented to manage independent sector pressures.

Efficiencies Variance (£m)

Latest ICS Performance (Nov-25) **-11.7** National Ranking n/a

ICS Trend (Nov-25)



Issue

- System delivered £312m of efficiencies as at month 8 against a plan of £324m therefore reporting a shortfall in delivery of £11.7m.
- The ICB reports a shortfall of £9.4m on delivery, with providers delivering a shortfall of £2.1m
- 92% of ICB efficiency plans are either fully developed or plans are in progress.
- System forecasting £581m efficiency delivery against a total plan of £572m, exceeding the plan by £9m
- As at month 8, 54% of the annual efficiency savings target has been delivered. Savings will need to be accelerated in the final 4 months of the financial year in order to deliver the forecast savings. This does largely reflect the profiling of the efficiency plan.

Action

- Chief Officer for System Improvement and Delivery reviewing progress against efficiency plans through FCOG group.

Delivery

- Review continuously and implement corrective action where there is potential slippage on plans.

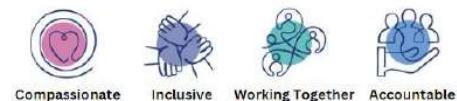
Meeting of the Board of NHS Cheshire and Merseyside

29 January 2026

Highlight report of the Chair of the Quality & Performance Committee

Agenda Item No: ICB/01/26/15

Committee Chair: Tony Foy, Non-Executive Member



Leading **integration** through collaboration

Highlight report of the Chair of the Quality & Performance Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting(s)	11 December 2025, 08 January 2026

Key escalation and discussion points from the Committee meeting

Purpose: To provide the Board with a summary of key discussions, decisions, and actions from the Quality and Performance Committee meeting.

ALERT – Key Risks, Concerns and Issues Requiring Escalation

Winter pressures

(December)

- Bed Occupancy*: Acute sector occupancy is at 95.9%, 2% higher than planned trajectory, contributing to corridor care and ambulance delays.
- Ambulance Response*: Category 2 response times have exceeded 60 minutes in recent weeks, though recent improvement noted.

The committee noted effective actions taken to prepare for increased demand and to respond to emerging pressures including surge capacity, enhanced infection prevention and control (IPC) measures, and workforce resilience planning.

- Flu Vaccination rates HCW*. Except for Bridgewater, ECT and WUTH all Providers vaccinated a higher % than last year. Overall ICB HCW rate is 45.3% with NWAS at 40.8%.

Individual Providers – AH, Bridgewater, CoCH, MCT, Clatterbridge all reached the locally agreed 50% target, LWH and Merseycare both only reached 39%.

To put this into context all trusts have, during the past five years, recorded rates of over 70% and nationally other systems and trusts performed at higher levels,

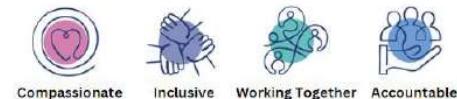
Population flu vaccination rates:

- ~68% (target 75%) Cheshire & Merseyside ranks 29th nationally, 49.4% of the eligible population.
- High uptakes in 65+ and Care Homes (71 and 66%)
- Place variation (overall eligible population) – Knowsley 40.8% to Sefton 56.8%
- Population groups – low levels in 18-64, approx. 35% and Pregnant 40.2% (but this is higher than last year)

(January)

Winter Pressures

- All acute trusts achieved <92% bed occupancy on 24–25 December, a key winter preparedness target.
- No trusts are currently experiencing sustained ambulance turnaround delays.
- Corridor care instances fell from 135/day to 110/day year-on-year.
- A&E attendance increased overall by 2.4%, but with large variation across trusts.
- Corridor care levels and 12-hour breaches have improved compared to 2024/25. Regular assurance visits undertaken to confirm compliance with 'Red Lines Toolkit' (full report at February committee) – feedback included



- LUFT IPC issues (flu/ Norovirus) reduced assessment areas and bed base - rapid diagnostics at front door to contain infections. Patients triple boarded in some ward areas and increased numbers of people nursed on corridors
- MWL Medical Examinations taking place on corridor (noting environment / privacy & dignity), NEWS 2 / timely observations noted. No patients with oxygen cared for on corridor as per SOP
- CoCH Trust moved temporary escalation capacity into SDEC offering better patient experience along with a new corridor/temporary escalation space in SDEC once those cubicles are full. Millbrook facility in ED now provides low stimulation environment for patients experiencing mental ill health has improved patient experience for people who are waiting for an inpatient mental health bed: delays beyond 24 hours reduced in December. Seeking assurance regarding use of toolkit in SDEC TES as this is an alternative to corridor care.
- Wirral FT Significant improvement around mental health waits. Transformation of estate (2 ambulance arrival areas) contributing to improved handover times. Alignment of current corridor numbers following bed increases within the ambulance handover areas.
- Mid Cheshire. Observational visit with call bells in place and staff allocated to care for these patients. Separate area was available for any care required to maintain privacy and dignity. The Trust report fully against utilisation of the red lines toolkit and now see this as BAU.
- East Cheshire. Pendant system in use for higher risk patients in waiting room. Assurance that the Trust have embedded the Red Line toolkit, completed daily
- Oversight demands from NHS England (e.g., 2-hourly calls including weekends) are placing significant stress on providers and ICB staff, impairing their ability to operationally resolve issues
- Although system performance is better than the same period last year (e.g., lower corridor care, some improvement in 4hr/12hr metrics), operational pressures remain volatile, with Trusts at escalation levels.

Vaccinations

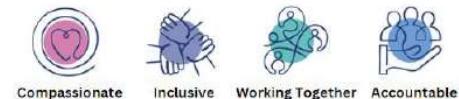
- Despite improvements across most providers, overall staff vaccination remains well below the levels needed to protect the system, with significant inconsistency in data quality and denominators. Lack of reliable data on primary care and social care staff remains a blind spot. National minimum expectations for uptake are set too low to support safe system functioning in winter.
- The committee considers that the current fragmented approach to population vaccination with unclear pathways should be addressed with NHSE. Early work by the ICB with healthcare workers and their employing organisations to improve uptake is essential.

ADVISE – Key Points for Board Awareness and Action

(January) Strategic Commissioning

Impressive rapid progress made on the Integrated Needs Assessment and Population Health Plan with strong analytical foundations

- The Integrated Needs Assessment is a substantial step forward, with:



- A robust life-course model.
 - Clear identification of risk, broad understanding of need,
- However, the emerging Population Health and 5 Year Plan risks becoming overly broad, focused on the Cheshire and Merseyside level not at Place and natural communities, with too many priorities for the workforce capacity available. The lack of data and analysis on wider determinants, especially Employment and Poverty will need to be addressed.
- The system needs to determine which priorities will genuinely be delivered in 2026/27, given workforce and financial constraints.
- Committee advised the population health team to incorporate data on marginalised groups:
 - Inclusion health groups (homelessness, substance misuse, Learning Disability).
 - Ethnicity data improvements.
 - Segmentation that goes beyond deprivation alone.
 - Neighbourhood Health model - Place-level segmentation and drill-down capability is essential for delivering the plan locally. BI work to match GP lists to neighbourhood footprints is underway but needs resourcing.

Delivery risk is high without clear prioritisation, timelines and implementation responsibilities.

ASSURE – Positives, Progress and Areas of Strength

December

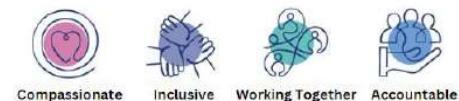
Maternity

LMNS detailed review

- *Continuity of care* - 14x enhanced teams are currently in place across 5 x C&M maternity providers (LWH, WUTH, WHH, MCHFT & CoCH), MWL (Whiston & Ormskirk) are progressing with the roll out of additional enhanced teams, with the LMNS supporting ECT to roll out a team. C&M continue to exceed North West and England performance for the proportion of Black/Asian women and those in the most deprived areas who are on a Continuity pathway
- *Saving Babies Lives* (a package of interventions to reduce stillbirth, neonatal brain injury, neonatal death, and preterm birth) As of Quarter 2 25/26, all maternity sites are on track.

Performance Improvements

- C&M continue to report the lowest rates of stillbirths when compared to GMEC & L&SC and England average (lower is better).
- C&M has reported a Preterm Birth rate lower than GMEC & L&SC and England Deliveries under 34 weeks are also lower than GMEC & L&SC and England average
- C&M has reported a lower rate of emergency and total c-sections than the England average. Variation in emergency c-sections evident.



- C&M has reported a Post Partum Haemorrhage rate lower than GMEC & L&SC and England
- Smoking at Time of Delivery – C&M at NW and England level but MWL and Women's recording higher rates

Exceptions

- **Breast milk at first feed** (higher is better) – C&M ICB continues to report a rate below the England performance. The development of a multi-agency C&M Infant Feeding Strategy (led by the LMNS) launched July 25, will help to facilitate continued improvements with all C&M providers working towards achieving accreditation with the UNICEF Baby Friendly Initiative (BFI).
- **Induction of Labour (IOL) as a % of deliveries** (lower is better) – C&M ICB continues to report a rate above the England average. However, this is likely to be due to the need for Trusts to achieve compliance with the Saving Babies Lives Care Bundle version 3 and NICE guidance recommendations (it should be noted that IOL delays are monitored by the LMNS within the C&M Maternity Safety SITREP,)

January

Continuing Healthcare (CHC) – outlier status and unwarranted variation reviewed

- Cheshire & Merseyside continue to be a national outlier in CHC spend and activity, especially Fast Track end-of-life packages.
- Significant internal variation between places and teams – especially Wirral and Southport/Formby – linked to historic outsourcing, inconsistent assessment practice, and workforce instability.
- Fast Track referrals remain disproportionately high, often without adequate challenge or alternative pathways; this is driving substantial cost pressure.

Clearer understanding of drivers and improvement actions

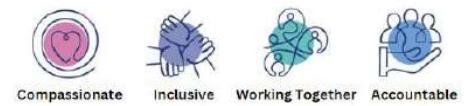
- The Committee commends:
 - Detailed analysis presented.
 - Clear identification of Fast Track as the primary driver of variation.
 - Planned action to bring Wirral CHC assessment functions back in-house.

Strengthen relationship with Local Authorities for CHC and community support

- Delivery of CHC improvement, frailty, falls prevention and end-of-life care improvement depends on:
 - Shared policy frameworks with councils (currently inconsistent).
 - Joint work on care home market management (especially in Cheshire).
 - Alignment of future roles under the new operating model.
- Concerns raised about risks of further fragmentation under the emerging national operating model; strong case made for CHC functions to remain within ICBs due to statutory decision-making.

Committee risk management

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



undertaken.

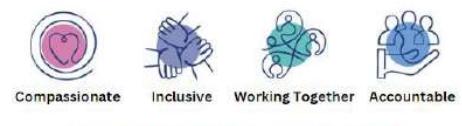
Corporate Risk Register risks	
Risk Title	Key actions/discussion undertaken

Board Assurance Framework Risks	
Risk Title	Key actions/discussion undertaken
P4 potential for major quality failures	Corridor Care – ‘Red Lines’ toolkit compliance and response to operational pressures reviewed. Action Plan to February committee
P1 Health Inequalities	Vaccination Programme – clinical staff uptake and Provider variation reviewed. Population uptake variance noted

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	Analysis of Provider performance undertaken
Maternity	Review of performance standards



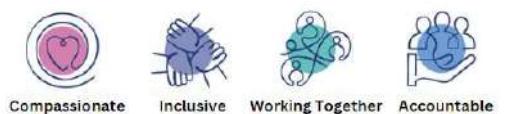
Meeting of the Board of NHS Cheshire and Merseyside

29 January 2025

Highlight report of the Chair of the ICB Audit Committee

Agenda Item No: ICB/01/26/16

Committee Chair: Mike Burrows, Non-Executive Member



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	02 December 2025

Key escalation and discussion points from the Committee meeting

Alert

The Audit Committee at its 02 December 2025 meeting:

- received an overview of proposed updates to its Terms of Reference (TOR), which have been refreshed following a detailed review against best practice within the HFMA NHS Audit Committee Handbook. The updates strengthen clarity, structure and alignment to contemporary governance standards, including enhanced statements on purpose, independence, membership requirements, private sessions with auditors, assurance mapping, cyber security oversight, collaborative system-level assurance, conflicts of interest, and Committee member training expectations. The Committee endorsed the changes to the Committees TOR (Appendix One).

The Committee recommends that the updated Committee Terms of Reference (Appendix One) is approved by the Board.

Advise

The Audit Committee at its 02 December 2025 meeting:

- reviewed the refreshed Committee Risk Register and noted that all three risks assigned to the Committee remain high, with particular focus on Risk G5, relating to inconsistent adherence to governance, financial and operational policies and procedures. Discussion highlighted significant recent control failures, with members agreeing that the current score of 9 for G5 understated the true exposure. The Committee therefore concluded that, pending strengthened controls and clearer assurance mechanisms, Risk G5 should be increased. Actions were agreed for the Associate Director of Corporate Affairs and Governance to update the risk register accordingly, explicitly incorporate budgetary control risks in the wording, consider whether G5 should be split into more specific financial and quality-related risks, and provide a summary of remaining legacy CCG policies still in use. The Committee also supported a review of internal audit coverage to ensure assurance on policy adherence, recognised the impact of organisational change on corporate memory and risk management, and agreed that ongoing monitoring of G5 is required across committees.
- received a summary update on procurement waivers approved between 01 June and 30 November 2025, during which four waivers totalling £1.6m were authorised in line with the ICB's Standing Financial Instructions and Scheme of Reservation and Delegation. The report reaffirmed that all waivers were appropriately justified and highlighted continued compliance with procurement legislation, including the Provider Selection Regime for healthcare services and the Procurement Act 2023 for non-health procurements. No breaches of Public Contract Regulations were



Compassionate



Inclusive



Working Together



Accountable

reported, and early engagement processes ensured no waivers were raised due to timescales. The Committee was provided with assurance that legal and financial risks remain well-managed through transparency notices, compliance checks, and strengthened procurement controls, with next steps including publication of updates to the Procurement Decision Register and appropriate contract notices. The Committee noted the report.

- received an update on the ICB's internal cyber security programme, noting limited progress pending confirmation of 2025/26 national funding, which has now been fully protected for delivery of the C&M Cyber Security Strategy. The report outlined current cyber risk management activity, outcomes from the 20 November 2025 system-wide cyber incident exercise, and progress against key areas including ISO 27001 alignment, DSPT/CAF-based assurance, Windows 11 migration, vulnerability management, secure email standards, and response to recent high-severity cyber alerts. Work is underway to consolidate digital providers to reduce variation, strengthen system resilience, and support strategic objectives relating to quality, integration, productivity, and safety. The Committee also reviewed the ongoing strategic cyber risk (BAF P11) and received assurance on approved capital and revenue allocations to support vulnerability reduction, incident response, and "secure by design" system development across Cheshire and Merseyside. The Committee noted the report.
- received an update on the Information Governance (IG) Service delivered by Mersey Internal Audit Agency, outlining progress since September 2025 across key workstreams including the CAF-aligned Data Security and Protection Toolkit (DSPT), the 2025/26 Record of Processing Activities (ROPA), the Information Asset Register and Data Flow Mapping, and continued implementation of IG audit recommendations. The report highlighted strengthened collaboration with Digital, Procurement and IT providers to address DSPT improvement actions, ongoing development of ROPA Version 2.0 incorporating corporate records, and successful delivery of targeted IG training for high-risk staff groups. Committee members were provided with assurance of effective oversight through the IG Management Group, consistent performance against the IG Service Delivery & Improvement Plan, timely handling of IG workload, and continued IG input into major ICS-wide Digital and Data programmes including CIPHA, the Shared Care Record, and the Federated Data Platform pilot. The Committee noted the report.
- received an updated ICB Section 75 Operational Policy, reflecting minor amendments required following changes to the ICB's Schemes of Reservation and Delegation (SORD) and Operational SORD approved by the Board in September 2025. The policy, which sets out the statutory framework for integrated working arrangements between Local Authorities and the ICB - including requirements for each Place to hold a Section 75 agreement for the Better Care Fund and any additional pooled budget arrangement - had been updated to ensure alignment with the revised approval structures. The Committee discussed and agreed that minor changes around updated wording on BCF spend to allow flexibility in approvals and future-proof against national changes needed to be included. With the inclusion of this amendment the Committee approved the updated policy.



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- received the Quarter Two ICB FOI performance update, noting that between July and September 2025 the ICB received 129 FOI requests and responded to 110, achieving 90.6% compliance with the statutory 20-day deadline—a slight reduction from the previous period. Delays in 12 cases were attributed to departments including Contracts, CCHC Finance, Population Health, Digital, Finance and Estates, primarily due to staff capacity, annual leave, and difficulty identifying information holders. The Committee also noted the application of 15 exemptions, eight requests for internal review (all upheld or clarified), and recurring thematic areas such as Continuing Healthcare, weight management, ADHD/ASC services, GP commissioning, and financial recovery. Overall, the paper provided assurance to the Committee on FOI handling processes while highlighting areas requiring continued monitoring and departmental responsiveness. The Committee noted the report.
- received the Quarter Two update on Subject Access Requests (SARs), noting that 24 SARs were opened between July and September 2025, with 29% completed within statutory timescales and 17% breaching, while half remained ongoing due to delays such as outstanding records, cases awaiting review, or requests placed on hold for clarification or identification. The report also highlighted continued challenges previously seen in Quarter One, including delays in record retrieval and cases breaching deadlines despite follow-up. The Committee discussed the breaches and plans for addressing and noted that challenges remain in meeting statutory obligations and the need to look at future service models. The Committee noted the report.
- received the Quarter Two update on the ICB's Conflicts of Interest (COI) and Declarations of Interest (DOI) compliance, which noted strong progress with a 90% DOI completion rate across 1,325 in-scope staff—an improvement from 82% and above the 85% target. A total of 1,488 declarations have been made since April 2025, with continued monitoring to address inconsistencies in declaration types and four recorded breaches of the Gifts and Hospitality policy. The Committee was asked to take assurance that COI management processes remain robust, to approve the rollout of Modules 2 and 3 of the national COI training (targeting staff in decision-making and leadership roles), and to note planned work to progress a new policy for working with digital/IT companies. The Committee approved the recommendation regarding roll out of Modules 2 and 3 of the national COI training and noted the contents of the report.
- received an update on Freedom to Speak Up (FTSU) activity across the ICB, highlighting themes raised during the October FTSU month and Q2 National Guardian Office data. Areas for improvement presented included strengthening corporate-place integration, clarifying the Place function, increasing leadership visibility, enhancing communication, supporting staff wellbeing, and introducing KPIs with regular assurance. Q1–Q2 data showed an overall reduction in total cases (30 to 21), with shifts across concern categories, notably increases in worker safety/wellbeing issues. The Committee noted the report.
- received the Internal Audit Plan progress report which provided Committee members with an update on audit activity since the last report to Committee. The report highlighted completion of several planned reviews—including *IT Supplier*



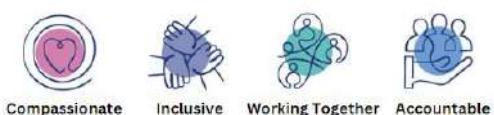
Management (Limited Assurance), Delegated Primary Care Functions Annual Self-Declaration (briefing issued), and *Risk Appetite*—alongside ongoing work on Quality of Commissioned Services, Specialised Commissioning, IT Critical Applications, Key Financial Systems, Cost Improvement Programme, and Equality, Diversity & Inclusion. The report confirmed no changes to the 2025/26 audit plan and noted MIAA's newly awarded status as an NCSC-assured provider under the Cyber Resilience Audit Scheme. The Committee noted the report.

- received an Internal Audit Follow-Up Summary report which provided an update on the implementation status of audit recommendations from previous reviews. The report highlighted that most areas demonstrated positive movement, with multiple recommendations implemented while some actions remain in progress or not yet due. A small number of items remain subject to further evidence or follow-up, though no critical issues were identified. Overall, the report provided assurance that follow-up processes are active and that the majority of recommendations due for completion have been addressed or are progressing appropriately. The Committee noted the report.
- received the Anti-Fraud Progress Report for December 2025, which confirmed that all areas of the anti-fraud work plan—Assure, Understand & Prevent, and Respond—are progressing as planned, with full compliance against the majority of the Counter Fraud Standard and only one component (Fraud Risk Assessment) rated Amber pending its scheduled refresh. Key activity reported included the transition to a new Anti-Fraud Specialist, delivery of multiple fraud awareness webinars linked to the new 'failure to prevent fraud' offence, issuance of a wide range of national and local fraud prevention alerts and guidance, and ongoing proactive work such as Fraud Prevention Checks, PHB fraud guidance, procurement fraud updates, and continued clearance of National Fraud Initiative matches. The report noted investigation activity for the period, with eight new referrals received, several cases closed, and a small number continuing into the next period, alongside confirmation that no fraud-related losses, recoveries, sanctions, or system weakness reports were identified in-period. The Committee noted the report.
- received a Winter 2025 sector update from the ICBs External Auditors which provided an overview of emerging national developments affecting Integrated Care Boards, including the national programme of ICB clustering and proposed mergers, forthcoming boundary changes planned for 2026–27; and the introduction of a multi-year financial planning framework requiring stronger financial discipline and alignment with new commissioning footprints. The update also highlighted major system-wide reforms to reduce NHS administrative costs, workforce and culture risks associated with mergers, and governance challenges inherent in joint working arrangements. The update report highlighted risks, assurance expectations and challenge questions for Boards as the NHS undergoes significant structural and financial change. The Committee noted the update.

Assure

n/a

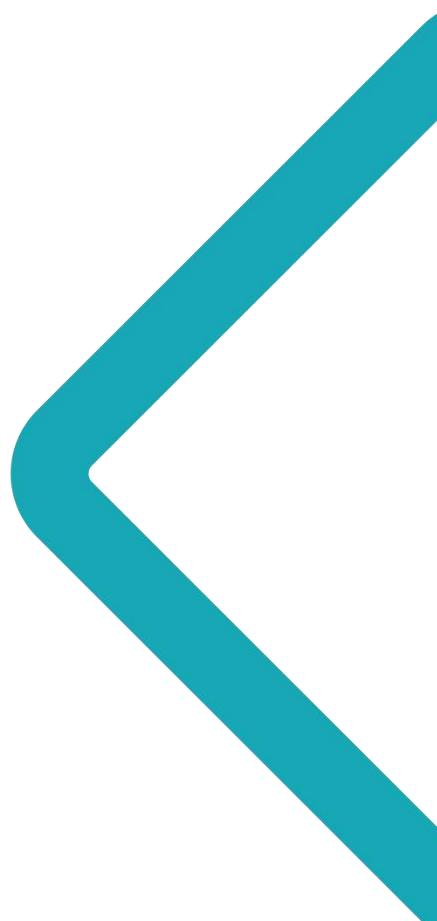
The next meeting of the Committee is scheduled for **03 March 2026**.



NHS Cheshire and Merseyside Integrated Care Board

Audit Committee

Terms of Reference



Document revision history

Date Approved by Board	Version	Revision	Comment	Author / Editor
01.07.22	1.0	Initial ToRs		Ben Vinter
29.09.22	1.1	Refreshed TORs following first meeting of the Audit Committee		Matthew Cunningham
28.09.23	1.2	Refreshed TORs following 05 September Audit Committee meeting		Matthew Cunningham
add date	1.3	Updated TORs to reflect best practice improvements following review against HFMA NHS Audit Committee Handbook		Matthew Cunningham

Review due: December 2026

V1:3 approved by the ICB Board on add date

Audit Committee Terms of Reference

Executive Summary

The Audit Committee ('Committee') provides independent, objective assurance to the Integrated Care Board (the Board or ICB) on the fitness and effectiveness of the ICB's:

- Governance, risk management and internal control (including Board Assurance Framework and three-lines model).
- Internal audit, external audit and counter fraud arrangements.
- Financial reporting (incl. annual report & accounts and AGS).
- Information governance, data quality and cyber security oversight.
- Freedom to Speak Up / raising concerns frameworks.
- System (ICS) risk oversight and collaborative assurance with partner committees

1. Establishment and Authority

1.1 The Committee is established by the ICB as a Committee of the Board as a non-executive committee under the ICB Constitution, Standing Orders (SOs), Standing Financial Instructions/Prime Financial Policies (SFIs/PFPs) and Scheme of Reservation & Delegation (SoRD). It operates with no executive powers other than those expressly delegated by the Board in these TOR *in accordance with its Constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD)*.

The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB. The Audit Committee has no executive powers, other than those delegated to as identified within the Constitution and SoRD and specified in these TOR.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is authorised to:

- Seek any information within its remit from any ICB employee or member; all are directed to co-operate.
- Obtain independent professional advice as required and commission reviews/investigations or task-and-finish sub-groups.
- ensure access for Internal Audit, External Audit and Local Counter Fraud Specialists (LCFS) to the Committee Chair
- investigate and approve any activity as outlined within its terms of reference
- commission any reports it deems necessary to help fulfil its obligations
- obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice
- create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may/ not delegate any decisions to such groups.
- commission, review and approve policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by the ICB Board.

For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the SoRD.

2. Purpose

2.1 The purpose of the Committee is to: ~~contribute to the overall delivery of the ICBs strategic objectives and provide assurance to the Board on governance, risk management and internal control processes.~~

- provide the ICB Board with independent, objective assurance that the ICB's systems of governance, risk management and internal control are designed and operating effectively across all activities supporting the delivery of statutory duties, strategic objectives and stewardship of public funds.
- protect the interests of patients, the public and taxpayers by ensuring truth and fairness in reporting, effective risk assurance, and proportionate controls.

3. Roles and Responsibilities

3.1 Duties

The duties of the Committee will be driven by the organisation's strategic objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

The Committee's duty is **to have oversight on and to assure the Board on:**

- Integrated Governance and Systems Risk
- Internal Audit
- External Audit
- Other Assurance Functions
- Counter Fraud
- Financial Reporting
- Freedom to Speak Up
- Information Governance
- Conflicts of Interest
- Management and Communication.

Providing assurance involves:

- **Triangulating multiple sources** of appropriate internal and external information, including:
 - Data analysis and contract performance intelligence
 - Patients', service users' and carers' reports, surveys, complaints, and concerns
 - Evidence from key system leaders
 - Other intelligence agreed to be important and reliable.
- **Remedial action:** Where assurance cannot be provided in part or in full, to provide the Board with details of remedial actions being taken and or being recommended.
- **Considering efficacy and efficiency:** Things are not only in place, but the right things are being done in the right way to achieve the right objectives, which support the ICS aims.

3.2 Integrated governance, risk management and internal control

The Committee seeks reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness, namely:

- **Integrated Governance:** receives assurance around the adequacy and effectiveness of the integrated governance, risk management and internal controls that are present across the whole of the ICBs activities as evidenced by key indicators that focus specifically on the ICB's activities, contributions or controls which support the achievement of its objectives, and to highlight any areas of weakness to the Board
- **Financial Management:** to ensure that ICB financial systems and governance are established which facilitate compliance with:
 - DHSC's Group Accounting Manual, including scope, management, patient and public involvement and continuous improvement
 - principles and guidance established in HMT's Managing Public Money
- **Assurance Processes:** to review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks by sound processes
- **Risk Management:** to receive assurance that the risks that relate to the achievement of the ICBs objectives are managed well. **The Committee has a role to review the Board Assurance Framework (BAF) and underlying risk management system; test the completeness and reliability of controls and assurances (including independent sources), and the delivery of actions to close gap. The ICB has adopted the three-lines model to triangulate assurance (management; oversight/compliance; internal audit; plus external regulators) and to identify duplication or omission**
- **Improvement:** receives assurance that the ICB identifies opportunities to improve governance, risk management and internal control processes across the ICB.

3.3 Internal audit

The Committee appoints, monitors and evaluates that there is an effective internal audit function that meets the **Global Public-Sector Internal Audit Standards (GSIAS)** and provides appropriate independent assurance to the Board. This will be achieved by:

- **Strategy and Plan:** the Committee considering the provision of the internal audit service and the costs involved, reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework. The Committee will ensure that the ICB has an internal audit Charter that is prepared in accordance with the **PGSIAS**
- **Major Audit Findings:** the Committee considering the major findings of internal audit work, including the Head of Internal Audit Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources. **The Committee is also responsible for monitoring timely and effective implementation of agreed actions, and arbitrate disagreements between auditors and management.**
- **Resources:** the Committee receives assurance:
 - that the audit resources are optimised through coordination between the internal and external auditors
 - that the internal audit function is adequately resourced and has appropriate standing within the organisation and
 - through monitoring the effectiveness of internal audit and carrying out an annual review.

The Committee has the authority, as delegated by the Board, to approve Internal Audit plans and any changes to the provision or delivery of related services.

3.4 External audit

The Committee appoints and monitors an effective external audit function and the external audit process and provides appropriate independent assurance to the Board. The Committee does this by:

Appointment and Performance:

- the Committee ensures that the ICB has appointed an External auditor in accordance with the Local Audit and Accountability Act 2014
- the appointment and performance of the external auditors is monitored and reviewed, including the cost of the audit and any issues of resignation and dismissal
- review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process
- market testing exercise for the appointment of an auditor is conducted at least once every five years, with a recommendation from the Committee being made to the Board with respect to the appointment of the auditor
- reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Scope:

- discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee and

Report

- reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

The Committee has the authority, as delegated by the Board, to approve External Audit plans and any changes to the provision or delivery of related services.

3.5 Other assurance functions

The Committee is authorised to review the findings of assurance functions in the ICB, and to consider the implications for the governance of the ICB. This includes the authority to:

- review the work of other committees in the ICB, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility.
- **the Committee may request deep dives from other ICB Committees on risk or controls relevant to the BAF**
- review the assurance processes in place in relation to financial performance of the ICB including the completeness and accuracy of information provided and where appropriate to advise the ICB of any assurance considerations for wider system working.
- review the findings of external bodies and consider the implications for governance of the ICB. These will include, but will not be limited to:
 - reviews and reports issued by arm's length bodies or regulators and inspectors: e.g., National Audit Office, Select Committees, NHS Resolution, CQC; and
 - reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g., Royal Colleges and accreditation bodies).
- **Oversee compliance with constitutional documents (Standing Orders, SFIs/PFPs, SoRD), including culture of compliance and safe decision-making.** **Standing Orders:** If, for any reason, the ICBs Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the board for action or ratification and the Audit Committee for review. Where a decision to suspend the ICBs Standing Orders has been approved by the Board, a separate record of matters discussed during the suspension shall be kept and made available to the Audit Committee for review of the reasonableness of the decision to suspend the Standing Orders.

- **Urgent Decisions by the Board:** any urgent decisions made by the Chair and Chief Executive, or relevant lead Director, on areas normally reserved to the Board, will need to be reported to the Board for formal ratification and to the Audit Committee for oversight.

3.6 Counter fraud

The Committee is authorised to:

- approve the ICBs counter-fraud and security management arrangements
- review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports, and ensure that these are scrutinised and challenged where appropriate.

The Committee is responsible for:

- ensuring that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.
- ensuring that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS Standards for Commissioners; Fraud, Bribery and Corruption.
- reporting concerns of suspected fraud, bribery and corruption to the NHSCFA
- ensure that the ICB monitors and complies with any Directions issued by the Secretary of State for Health on fraud and corruption.

3.7 Freedom to Speak Up/Raising Concerns

The Committee is authorised to seek assurance on the Freedom to Speak Up arrangement for the ICB, namely:

- **Arrangements for raising concerns:** To review the adequacy, effectiveness and security of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters, **and monitor that staff who speak up are protected from detriment. The Committee will receive regular reports from the ICB FTSU Guardian(s)**
- **Investigation and Action:** The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

3.8 Information Governance (IG), data quality and Cyber Security

The Committee is authorised to seek assurance on the information Governance arrangements **and compliance** within the ICB, namely:

- **Timeliness of data:** The Committee will receive regular updates on IG compliance (including uptake & completion of data security training), data breaches, **data quality** and any related issues and risks.
- **Reports:** The Committee will receive and review:
 - the annual Senior Information Risk Owner (SIRO) report,
 - the submission for the Data Security & Protection Toolkit (DSPT)
 - reports on audits to assess information and IT security arrangements, including the DSPT audit
 - and any other relevant reports and action plans
- **Cyber Security:** **assure oversight of cyber security risk management (policy, capability, alert response), commissioning additional assurance where material**

The Committee will also be required to provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

3.9 Financial reporting

The Committee is authorised to seek assurance on the financial reporting arrangements of the ICB, namely:

- To monitor the integrity of the financial statements of the ICB [and in-year reporting](#), and any formal announcements relating to its financial performance.
- To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.
- To review the annual report and financial statements (including accounting policies) before submission to the Board focusing particularly on:
 - the wording in the [Annual Governance Statement](#), [ensuring consistency with the Committees view of internal control](#), and other disclosures relevant to the Terms of Reference of the Committee
 - changes in accounting policies, practices and estimation techniques
 - unadjusted misstatements in the Financial Statements
 - significant judgements and estimates made in preparing of the Financial Statements
 - significant adjustments resulting from the audit
 - letter of representation; and
 - qualitative aspects of financial reporting.
- **Losses and Special payments:** the Committee will receive reports regarding losses and special payments (including bad debts to be written off).
- **Prime Financial Policies:** the Committee will receive reports where the ICBs prime financial policies are not complied with, which will include full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance. The Committee has the authority to ratify the reports or refer on for further action.
- **Retrospective expenditure:** any breaches in relation to expenditure approval will be reported to the Audit Committee
- **Standing Financial Instructions:** to receive reports on incidences where there has been a failure to comply with the ICBs Standing Financial Instructions, which will include full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance. The Committee has the authority to ratify the reports or refer on for further action.
- **Tender waivers:** to receive reports on tender waivers as approved by the ICBs Finance, Investment and Resources Committee.

3.10 Conflicts of Interest

~~The Committee is authorised risk.~~ The Committee shall seek assurance that that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective. The Committee shall do this by:

- **Reports:** receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.
- **Representation:** ensuring there are robust Conflicts of Interest Guardian arrangements are in place and communicated to staff and all stakeholders. The Chair of the Audit Committee will be the nominated Conflicts of Interest Guardian for the ICB.

3.11 Management and Communication

The Committee is authorised to seek assurance on the quality of decision making and communications by:

- **Management:** The Committee can:
 - request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
 - request specific reports from individual functions within the ICB as they may be appropriate to the overall arrangements.

- receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of the ICB's standing orders, in order to provide assurance in relation to the appropriateness of decisions and to derive future learning.
- **Communication:** The Committee has the authority:
 - To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally.
 - To develop an approach with other committees, including supporting the ICB with the Integrated Care Partnership, to ensure the relationship between them is understood.

4. Authority

~~The Audit Committee is authorised by the Board to:~~

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

~~For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the SoRD,~~

4. Membership & Attendance

The Committee members drawn from the **Non-Executive members** of the ICB Board **and** shall be appointed by the Board in accordance with the ICB Constitution. Members will possess between them knowledge, skills and experience in accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

Neither the Chair of the Board, nor employees of the ICB will be members of the Committee.

The Board will appoint **no fewer than** at least three Non-Executive members **of** to the Committee, ~~drawn from the Non-Executive Members of the Board. Other members of the Committee need not be members of the Board, but they may be.~~ At least one member must have recent and relevant financial experience (e.g., financial reporting/audit)

~~As a minimum the membership of the Audit Committee will therefore be:~~

- ~~at least three of the ICBs Non-Executive members.~~

The Committee may also choose to appoint other individuals to be **non-voting** members of the Committee, **for additional expertise/independence**, drawn from:

- system lay persons or Non-Executive Directors.
- ~~at least one~~ ICB Partner Board Members.

Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- Director of Finance or their nominated deputy.
- Associate Director of Corporate Affairs and Governance, or their nominated deputy
- representatives of both internal and external audit.
- individuals who lead on Information Governance, risk management and counter fraud matters.

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

Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter. *including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.*

The Chief Executive should be invited to attend the meeting at least annually.

The Chair of the ICB may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations. The Chair of the ICB Board can also agree attendance to additional meetings via discussion with the Committee Chair.

All members of the Committee will receive an induction, covering the key areas of the Committees responsibilities. Committee members will have access to relevant training to support development, including briefings from Auditors, HFMA and NAO).

Attendance

Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

Access

Regardless of attendance, External Audit, Internal Audit, Local Counter Fraud and Security Management providers will have full and unrestricted rights of access to the Audit Committee **and to the Chair of the Committee in between meetings.**

5. Meetings

5.1 Leadership

In accordance with the constitution, the Committee will be chaired by a Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience **(audit / finance / governance) making** them suitable to chair the Committee.

The Chair of the Committee shall be independent and therefore may not chair any other ICB committees. They will be mindful of their role should they participate in any other committee.

Committee members may appoint a Deputy Chair.

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

5.2 Quorum

For a meeting to be quorate a minimum of two Non-Executive Members of the Board are required, including either the named Chair or the Deputy Chair of the Committee. ICB Board members must form the majority of the membership at a meeting of the Committee.

If the named Chair, or Deputy Chair, are both unable to attend a meeting, and the meeting is required to proceed on the agreed date, then a suitably experienced ICB Non-Executive member will Chair the meeting with a second ICB Non-Executive Member attending. Where these quorum requirements are unable to be met the meeting date will be rearranged.

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

If on an occasion a Committee meeting is due to start but the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. Alternatively, the meeting can be called to a halt and an agreement reached to rearrange an additional meeting.

5.3 Decision-making and voting

Decisions will be taken in accordance with the Standing Orders and within the authority as delegated to the Committee. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

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

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

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. Decisions will be recorded and formally minuted and ratified at a subsequent formal meeting of the Committee.

5.4 Frequency

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

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

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

Meetings of the Committee with members only present, alongside representatives from Internal and External Audit, will be arranged following each formal meeting of the Committee

~~Papers for the meeting will be issued ideally one week in advance of the date the meeting is due to take place and no later than 4 working days.~~

5.5 Administrative Support

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

- the agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead. ~~Papers for the meeting will be issued ideally five working days in advance of the date the meeting is due to take place and no later than 4 working days~~

- attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements
- records of conflicts of interest, members' appointments and renewal dates. Provide prompts to renew membership and identify new members where necessary
- good quality minutes are taken in accordance with the ICBs standing orders and Corporate Standards Manual and agreed with the chair. Keep a record of matters arising, action points and issues to be carried forward
- the Chair is supported to prepare and deliver reports to the Board
- the Committee is updated on pertinent issues/ areas of interest/ policy developments
- action points are taken forward between meetings and progress against those actions is monitored.

6. Accountability and Reporting Arrangements

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

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

The Chair will provide assurance reports to the Board at the subsequent meeting of the Board following a meeting of the Audit Committee and shall draw to the attention of the Board any issues that require disclosure to the Board or require action. Minutes and assurance reports of a confidential nature from the Audit Committee will be reported to a subsequent meeting of the Board in private.

The Audit Committee will provide the Board with an Annual Report, timed where possible to support finalisation of the accounts and the Annual Governance Statement. The report will summarise its conclusions from the work it has done during the year specifically commenting on:

- the fitness for purpose of the assurance framework
- the completeness and 'embeddedness' of risk management in the organisation
- the integration of governance arrangements
- the appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements and
- the robustness of the processes behind the ICBs approach to the review and scrutiny of provider quality accounts
- **performance of internal/external Audit and Counter Fraud**
- **committee effectiveness, lessons learned and forward priorities.**

7. Behaviours and Conduct

ICB values

Members will be expected to conduct business in line [with and uphold the Nolan Principles](#), the ICB values and objectives

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

Equality and diversity

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

8. Review

The Committee will conduct an annual self-assessment, against recognised checklists (HFMAS/NAO tools) so as to review its effectiveness ~~at least annually~~, with an improvement plan developed and monitored by the Committee.

Every 3-5 years an external effectiveness review (or earlier if the Board deems necessary) will be commissioned.

An annual skills & diversity matrix for Committee members will be reviewed by the Committee.

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

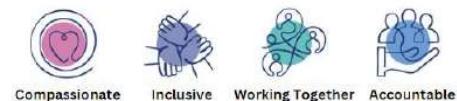
Meeting of the Board of NHS Cheshire and Merseyside

29 January 2026

Highlight report of the Chair of the System Primary Care Committee

Agenda Item No: ICB/01/26/17

Committee Chair: Tony Foy, Non-Executive Member



Leading **integration** through collaboration

Highlight report of the Chair of the System Primary Care Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting(s)	18 December 2025

Key escalation and discussion points from the Committee meeting

Alert

GP Prescribing Risk/Approach - The committee noted current overspend above plan reflecting several factors discussed at the meeting. A monitoring system is being implemented, with anticipated benefits expected in the coming months. Finance reports a significant overspend on primary care prescribing. The committee asked for further assurance on the reported discrepancies and ensure reliance on accurate information.

Advise

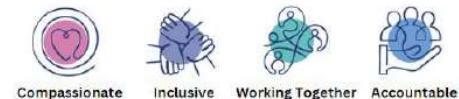
Digital – The Committee supported the proposed approach re slippage on the ICB's capital funding allocation in 2025/26 which will support the delay of the additional agreed costs of digital elements back into Practices, until 1st April 2026 - and to use the budget associated with AccuRX to deliver cost savings.

Finance - The committee received an update in relation to finance - including an updated breakdown of the Additional Roles Reimbursement Scheme (ARRS) allocation with some further clarifications noted. GPIT is likely to overspend due to increased activity beyond the original plan with mitigation options discussed at the meeting.

Optometry - Special Education Settings Eye Care Services – The Committee noted the approach agreed by the Executive Committee in December and procurement timeline, progress to be reported by exception.

Advice and Guidance – The committee received an update on this area which has now seen increased assurance and focus from NHS England - including further asks in respect of a recovery/insurance plan. Given the low spend across the ICB in respect of the Enhanced Service, the committee supported the removal of the current cap - which has now been lifted. The committee also agreed the terms of reference for the overarching system primary / secondary care interface group and noted that an advice and guidance steering group remains in place currently to help oversee the actions/assurances required in this area.

Primary Care Quality – From the report submitted, the committee requested further assurance - and additional actions were agreed - in respect of the ultrasound results issue. Under current governance it was noted that GPs should raise concerns re this to Place quality in the first instance and escalated to Quality and Performance – and this committee would receive an update also.



Assure

Contracting/Commissioning - The Committee received an update on the template agreed for monthly primary care assurance reporting to NHS England which covers all four contractor groups. It was noted that for optometry, GOS (General Ophthalmic Services) fees had been announced since the paper was completed. Dental contracts reforms and expectations were noted, with ongoing work to assess the impact from 2026/27. Assurance was received that Christmas community pharmacy rota plans have been communicated. Progress/status on key general practice contracting areas from 1.10, such as on-line consultations, were given – and assurance re actions for follow up of any non-compliant areas.

Community Pharmacy – The committee received an update on the 7 sites who were part of the National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme. The aim of the programme is to establish a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care. The committee noted further discussion/agreement was required regarding funding for this post 31.3.2026 when funding ends.

Key Strategic Delivery areas

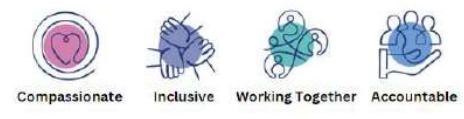
(1) Access to General Practice –

Patient Experience - As part of the agreed assurance in this area, it had been agreed that the Healthwatch representative on the committee would update on current access to general practice feedback/soft intelligence from patients (on behalf of all Healthwatchs' in the ICB area) as part of this item. Challenges remained particularly around securing appointments, telephone pressures, and uncertainty in what would happen to patients on contact with the practice – but there was variation. Positive feedback highlighted a feeling of being listened to by professionals - and clinical outcomes. An action was taken to look at any further areas of communication by the ICB to support patient understanding of care navigation and the additional/new roles in general practice.

June 2025 access plan submission – the committee noted the update outlined in the format of the original plan, including data and narrative in key areas. It was noted that variation in access remained a key assurance area and NHS England would be undertaking further specific asks in this respect. Additional communications support outlined above and a recognition of increasing demand were noted as part of the discussion.

(2) Neighbourhood Health – the committee received a verbal update on current work and noted that a national blueprint was still awaited. At the February meeting, a more detailed update paper would be presented, from the ICB lead, recognising primary care key's role in this area.

Risks – The Committee received an update with regards to progress and proposed actions/arrangements for the continued reporting of risks and assurance to the



committee. Progress with some specific risks were noted and a further detailed paper would follow at the next meeting, with the new reporting/template asks incorporated.

Achievement of the ICB Annual Delivery Plan

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

Focus Area	Key actions/discussion undertaken
Access to General Practice	Update as above including patient experience feedback and access variation plan.

Committee risk management

Individual risk reporting will return to the Committee at the next meeting - but a general progress update was received noted above in the paper narrative.

Meeting of the Board of NHS Cheshire and Merseyside

29 January 2026

CONSENT ITEMS

All these items have been read by Board members and the minutes of the January 2026 Board meeting will reflect any recommendations and decisions within, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.			
AGENDA NO	ITEM	Reason for presenting	Page No
ICB/01/26/20	Board Decision Log (CLICK HERE)	For information	-
ICB/01/26/21	Confirmed Minutes of ICB Committees Click on the links below to access the minutes: <ul style="list-style-type: none"> • Audit Committee (CLICK HERE) • Finance, Investment and Our Resources Committee (CLICK HERE) • Quality and Performance Committee (CLICK HERE) • System Primary Care Committee (CLICK HERE) • Women's Hospital Services in Liverpool Committee (CLICK HERE) 	For assurance	Page 178