NHS
Cheshire and Merseyside

Questions Raised – July 2026 CM ICB Board

Question Received	By
As a citizen living within the NHS Cheshire and Merseyside Integrated Care Board, as well as being myself an ADHD UK Ambassador with my own diagnosis of ADHD, I would like to ask the ICB what they are doing about the current waitlists and inability to pick up new patients to be tested for ADHD and Autism as a result of the existing list being too large to handle? The NHS appears to be restricting ADHD and Autism diagnoses as opposed to actually supporting neurodivergent people in this country, often in line with the spread of misinformation in the media including non-factually supported claims that 'ADHD is over diagnosed' when it is in fact vastly still misdiagnosed. Hence, what is the Cheshire and Merseyside ICB doing to support neurodivergent people either with a diagnosis of or seeking an assessment for ADHD and/or Autism? While I am aware this is a national issue, I am formally submitting the question for my local region's ICB to discuss at the next meeting on 30th July.	Amy Cocksedge

Response

Historically Adult ADHD and Autism assessment services in secondary care have focused mostly on giving a diagnosis rather than meeting needs. This means many people who are struggling are not getting early help. If this keeps happening, waiting lists will continue to grow, and those with the greatest need will wait longer for support.

Being referred for an ADHD or autism assessment does not always mean someone will receive a diagnosis. The assessment is done to understand what is causing the difficulties, and sometimes the outcome may be something different.

The rising demand costs a lot of money and is putting pressure on the NHS. There are many NHS and private organisations offering ADHD assessments. This means people are not always getting the same type of care.

As a result of all these challenges, our Adult ADHD and Autism services in Cheshire and Merseyside need to change so we can understand and support people better.

Our plan for better Adult ADHD and Autism services in Cheshire and Merseyside aims to:

- **understand people's needs in a clear and fair way**
- **help more people get support without needing a diagnosis**
- **increase the number of ADHD and Autism assessments through development of new primary care services**
- **make sure specialist services are available for people with the most complex needs.**

A new and innovative care model for Adult ADHD is now being rolled out across Cheshire and Merseyside in 2026/27. It aims to support anyone who needs help with ADHD symptoms, not just diagnosis. It helps people get support early, so they can better

manage their symptoms as well as providing diagnostic assessment for adults whose symptoms meet certain clinical criteria. This primary care service will help people understand their needs and find useful information, education, and support. GPs who have undertaken extra ADHD training will work alongside Neurodevelopment Practitioners to provide the service.

In addition, we have commenced a small pilot to test a similar approach in the community for Adult Autism. This pilot will test out whether the use of additional clinical Neurodevelopmental practitioners working alongside trained GPs can provide support to those requiring an Autism assessment, in collaboration with psychiatrists.

In addition to the development of primary care capacity, we are working with secondary care Providers to ensure a more standardised service offer for patients and that patients with the greatest clinical need are prioritised.

Question Received	By
It concerns the Board's oversight of the Single Improvement Plan and NHS England's enforcement undertakings, including the quality-governance requirement in paragraph 2.1. Under NHS England's enforcement undertakings and the ICB's Single Improvement Plan, what case-level trace-through testing has the Improvement and Delivery Oversight Committee commissioned or completed to assure the Board that Place-level quality intelligence, including equality-related concerns, is consistently captured, risk-profiled and either escalated or supported by an auditable, recorded decision not to escalate? Please identify the testing undertaken, its date and sample scope, where the findings were reported, and any resulting actions.	Luke Sampson

Response

The ICB Quality & Performance Committee receives a monthly assurance report that relates to each of the 9 local authority footprints that reflects geographically commissioned services. These reports will detail any risks to quality and safety, as well as any associated investigative outcomes that have been undertaken. The Chair's highlight report then details to Board of those issues requiring Board level oversight, whether in an alerting, advisory or assurance capacity. These reports are detailed within Board papers.

The ICB has a robust approach to Equality/Quality Impact Assessment (EQIA) processes, with an Executive led weekly panel to risk assess the impact of any proposed population-based service change and further inform commissioning plans. A quarterly report is received by Quality & Performance Committee that details each EQIA undertaken and its outcome.

Question Received	By
In response to concerns raised regarding the financial pressures facing NHS organisations within the Cheshire and Merseyside region by the BMA, the Minister of State for Health earlier this year stated that: "the Department of Health and Social Care has provided over £238m of emergency cash financing support to Trusts and Foundation Trusts within the ICB this year to ensure it can continue to meet its financial obligations and maintain services." Given the scale and significance of this support, could the Cheshire and Merseyside ICB provide further information on the emergency cash referenced by the Minister? Including: a. Which NHS Trusts and Foundation Trusts within the Cheshire and Merseyside ICB received this emergency cash financing support; b. The amount and date of funding provided to each organisation; c. The circumstances that led to each organisation receiving emergency cash support; d. How the level of support provided to each organisation was determined; e. Whether any of the funding was subject to specific conditions or restrictions on its use; f. Whether any element of the support was ringfenced for particular purposes, including maintaining services or addressing specific operational pressures; and g. Whether the funding is repayable, and if so, the terms and conditions attached to repayment.	Ben Jones

Response

a. Which NHS Trusts and Foundation Trusts within the Cheshire and Merseyside ICB received this emergency cash financing support and; (b) the amount and date of funding provided to each organisation.

As the process for assessing applications for emergency cash financing support are carried out by NHS England, the ICB is not aware of the exact date that funding was transferred to each provider. We are aware of when the approval was made for 2025/26, which is as per the table below:

	April	September	October	November	December	January	February	March	2025/6
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Countess of Chester		1.3	6.8	3.7			5.7	5.8	23.3
Liverpool Womens		3.8	2.5		3.0	2.5	6.8	4.0	22.6
MWL		10.7	11.0						21.7
Warrington & Halton		4.6	4.0	2.4	4.9	3.3		8.0	27.2
WUTH	8.0	10.0	5.5	6.0	6.5	4.0	2.0	16.3	58.3
East Cheshire							4.7	4.7	9.4
LUHFT			13.8		8.4	23.8	9.7	20.0	75.8
TOTAL	**8.0**	**30.4**	**43.6**	**12.1**	**22.8**	**33.6**	**29.0**	**58.8**	**238.3**

From 2026/27 It is no longer a requirement for Providers to copy the ICB into their emergency cash applications to NHSE.

c. The circumstances that led to each organisation receiving emergency cash support;

The ICB cannot comment on the exact circumstances, other than each organisation routinely undertakes cashflow forecasts as part of the process of seeking cash support.

d. How the level of support provided to each organisation was determined;

NHS England assesses each application and determines the level of support.

e. Whether any of the funding was subject to specific conditions or restrictions on its use; (f) Whether any element of the support was ringfenced for particular purposes, including maintaining services or addressing specific operational pressures;

The ICB is not aware of any specific conditions, restrictions, or ringfencing, that would be between NHS England and the provider.

g. Whether the funding is repayable, and if so, the terms and conditions attached to repayment.

The ICB cannot answer this question, it would need to be addressed to the provider or NHS England.

Question Received	By
NHS Talking Therapies in St Helens continues to experience very long waiting times for face-to-face therapy, with waits reported to be around **250 days**. To help manage demand, many people are being offered telephone therapy. While telephone support can be appropriate for some, it is not a suitable or effective alternative for everyone, and many people continue to wait a significant length of time for face-to-face support. I also understand that there were plans for NHS Talking Therapies in St Helens to move into dedicated premises, with an expectation that this would happen around **October 2025**. However, the service still does not have its own dedicated base. **My question is:** Can the Board explain why NHS Talking Therapies in St Helens still does not have dedicated premises, provide an update on the current position, and outline what specific actions are being taken to reduce waiting times for face-to-face therapy? In addition, does the Board routinely compare outcomes for people receiving telephone therapy with those receiving face-to-face therapy, and how is that evidence being used to inform future service planning and investment? As someone who works closely with local mental health services and people accessing support, I regularly hear concerns about the length of time people are waiting for face-to-face therapy and the impact this has on their recovery. I would welcome an update on the Board's plans to improve access to timely, face-to-face psychological support in St Helens. Thank you for your time, and I look forward to your response.	Claire Eddleston

Response

Question: Can the Board explain why NHS Talking Therapies in St Helens still does not have dedicated premises, provide an update on the current position, and outline what specific actions are being taken to reduce waiting times for face-to-face therapy?

Board can confirm that Mersey Care NHS Foundation Trust, provider of Talking Therapies, have signed a lease to secure space that will provide a base for the Talking Therapies team as well as capacity to see 100 patients per week face to face.

Following assessment, waiting times for Step 2 Talking Therapies* are currently 21 days to access Silver Cloud, 28 days to access Skills for Wellbeing and 45 days for a face-to-face appointment with a Psychological Wellbeing Practitioner (PWP); waits for the face-to-face appointments will continue to improve as staff become fully trained, with Trainee practitioners working to a 50% caseload.

Waiting times for Step 3 Talking Therapies for most service users are within 18-24 weeks.**

Additional steps to those mentioned above, being taken to reduce waiting times to access face to face support in the immediacy for Talking Therapies, include creating additional capacity by accessing Bank Staff as well as utilising provider partner Xyla.

Ongoing workforce planning, recruitment and training is taking place to ensure sufficiency for the service to be fully compliant with National and Local standards by 2028/29.

***Step 2 Talking Therapies refers to low-intensity, brief psychological treatments, for mild to moderate needs, typically featuring guided self-help, structured online courses, and group workshops.**

****Step 3 Talking Therapies refers to high-intensity, face-to-face or online psychological treatments for moderate to severe needs, typically involving support delivered by specialized cognitive behavioural therapists.**

Question: In addition, does the Board routinely compare outcomes for people receiving telephone therapy with those receiving face-to-face therapy, and how is that evidence being used to inform future service planning and investment?

Although telephone therapy is offered to service users, the main delivery method is through virtual or face to face appointments. Outcomes for the St Helens service are generally above target, with 53% of service users achieving "Reliable Recovery" against a target of 51% and 70.5% achieving "Reliable Improvement" against a target of 69%.

It should be noted that outcome measure definitions have recently been revised as per National standards so there is a period of transition taking place and fluctuations with data could be observed.

Mersey Care NHS Foundation Trust is currently reviewing data including outcomes with the intention of producing a paper to outline future trajectories and areas for investment.

Question Received	By
Re: Listening to women about the maternity crisis. It is disappointing to read the report to the ICB following the Ockendon and Amos reports on the state of maternity. The loudest message from the reports is “Listen to women.” The answer is not more regulations. It is listening to women, women having babies, women who have lost babies, women who are not having another baby because of their previous experience, women who want to have babies. Listening to families who have lost a mother in childbirth, and listening to women in the NHS workplace. Listen to women who had babies in better days. We need to see women and families being listened to with respect and their comments being addressed at the time and being fed back into the service. Many women in Cheshire and Merseyside may have issues to raise. Raising intensely personal and hurtful experiences can re visit trauma and many choose not to do so. You will need properly trauma informed processes to make this work, but you should give them opportunities to do so, especially now while the issue is front and centre of the news. Hopefully, this need will reduce as improvements are made, but the opportunity should remain. We do not need more regulations. Both reports showed how that worthwhile regulations there are already, but they are too cumbersome for busy maternity services possibly to use effectively. At the core of this problem, we need midwives with time to think, to make connections with the women they support. We need midwives with confidence to raise concerns and to take action, and a culture that lets them raise concerns without fear of bullying. We need world class, in person, in service training. This all means increased staffing. We need more midwives in the maternity wards. At this time of national conversation about maternity care, the board needs to listen to midwives speaking to you, without fear or favour, either individually or through representation of their choosing. Similarly with obstetricians, especially the more junior doctors who are most vulnerable to bullying. Do not expect every conversation to be positive but have them anyway. You might even win back some who have left in protest at the state of maternity services. We need to reinstate the model of maternity skills being passed through the generations. We need trusts with sufficient funds to allow such improvements and the knowledge and will to make them. We need people who know maternity inside out, and the confidence and courage to speak out on the boards, talk with women using the service, and listen to and interact with staff visibly.	Felicity Dowling

£10.6 million being made available for more midwives in 2026/27 is about £2 each for each delivery, hardly respectful of the scale of the problem; “Here’s twenty quid, love, go buy some flowers”. Whilst we are delighted two hundred or so newly qualified midwives will get their first post, it does not touch the sides of the need. For all our mothers, sisters, daughters, friends, lovers and every baby, improve maternity realistically, with respect and resources.	

Response

The ICB fully supports the importance of listening to staff and the population who use the services we commission. This is vital in informing and improving what we commission in order to improve outcomes.

The ICB agrees with the imperative need to listen to women and families in maternity services specifically and work in partnership with our maternity providers in Cheshire and Merseyside, who do this at organisational level through their Maternity and Neonatal Voices Partnerships.

The ICB, through the work of its maternity team, engage with providers and their MNVP teams at C&M level and ensure their voice is represented at the ICB Maternity Assurance Board. The ICB will adopt the developing Patient Reported Experience Measures that are due to be published for maternity services.

We appreciate the additional national investment of £10.6 million into the midwifery workforce, which will bolster current resource allocations, and the ICB will fully engage in the national roll out of staff listening events planned from September 2026 onwards, aligned to the findings of the Amos Review.

Question Received	By
There is concern in Garston about the closure of Mersey Care Moss House and the opening, virtually next door, of the SWAGGA PCN Neighbourhood Health hub, which in turn appears to have no funding? Could the public have some clarification? Where do these two developments fit into your plans? we can see no mention of them in your papers, the only mention of neighbourhood being on page 107.	Felicity Dowling

Response:

Mersey Care have confirmed they have no plans to close Moss House.

SWAGGA Primary Care Network (PCN) are based in the South Liverpool Treatment Centre – this is not a new development.

It remains a key site for us and forms part of our neighbourhood planning. SWAGGA PCN are one of a number of providers who use the site.

Question Received	By
Regarding the minutes on p.7 and 8 on the public engagement plan which was approved Although 3 public meetings were held as part of the public engagement plan, why were no notes taken of the public's input into the public meetings? This surely was an opportunity for some qualitative input? Why was the meeting in Sefton held -at a time in the afternoon at peak time for picking up children from school? -at a venue 15 minutes' walk from the nearest train station -at a venue with few buses going to the venue?	Lesley Mahmood

Response

Although 3 public meetings were held as part of the public engagement plan, why were no notes taken of the public's input into the public meetings? This surely was an opportunity for some qualitative input?

As stated in both the promotional information provided for the events, and during the introduction section of each session, the purpose of these public events was to provide people with information on the proposed changes to high risk and complex gynaecology and maternity care services in an accessible, face to face format, to give people who might find it difficult to engage online an alternative and more supported way in which to participate, and to give people an opportunity to ask any clarification questions they might have.

We also clearly explained at the outset of each event our reasons for not recording anyone's questions, comments or verbal feedback during the events, which was to ensure that we captured everyone's views in a fair, equal and consistent way throughout the process.

We provided plenty of space for qualitative views to be expressed in the main questionnaire, which as stated was our primary mechanism for collecting views during this engagement process, primarily because it makes the analysis of feedback phase much easier to manage.

Other reasons for not summarising people's spoken comments during these sessions was to help eliminate the risk of anyone's views being misrepresented, impartially or inaccurately recorded or interpreted, which has been feedback we have previously received when we have run other processes in this way - and we are always aiming to learn from experience, and refine and improve our approach to engagement.

In addition, this decision also helps us to ensure that some people's opinions aren't inadvertently elevated over other people's by being recorded multiple times throughout the process (eg. by completing the questionnaire, and through their attendance at multiple events). Our aim throughout every engagement process is to hear from as wide a range of views, perspectives and experiences as possible, not to record the same people's views multiple times.

Why was the meeting in Sefton held
-at a time in the afternoon at peak time for picking up children from school?
-at a venue 15 minutes' walk from the nearest train station
-at a venue with few buses going to the venue?

Decisions on venue locations and timings for public events are made by balancing a number of different factors, including local venue availability, accessibility and costs of venue hire, the availability of clinicians to attend and present, our social value commitment to supporting community partner venues, and ensuring that we provide events across a range of different times of day to suit different needs across a spread of events.

We recognise that whenever and wherever we hold a face-to-face event, we cannot meet everyone's requirements or needs – it will always be convenient for some people, and not others – and this is part of why our engagement processes do not focus on the delivery of public events like this more heavily. We recognise that it is not the most effective method of engaging with a large number of service users.

It is important to remember that the public meeting held in Sefton was not the only face to face or online meeting or opportunity provided for Sefton residents and stakeholders during the six-week process, and that we were not only aiming to engage with the parents with school aged children either. Many of our gynae service users are also older women, still childless women, and women dealing with infertility issues.

In terms of the specific criticisms of the accessibility of this venue, it was chosen because it is located between two bus stops, one approximately 36 metres away and the other approximately 77 metres away from the venue. Both stops are served by the 58 and 58A buses, which travel between Queen Square in Liverpool city centre and Netherton, and these services link into the wider bus and Merseyrail train network that serve Merseyside. It was also located in easy walking distance of several large residential areas in Bootle, which is an under-served community. Free on-site parking was also provided for those who wanted to travel by car too.

Question Received	By
I am concerned to see little progress on abolishing the Winter crisis in the hospitals. We know this crisis costs many lives.16,644 excess deaths in England were linked to long A&E waiting times (12 hours or longer) in 2024 according to the Royal college of Emergency Medicine The reports in your papers mean that the people of Cheshire and Merseyside will have poor care and staff will work under impossible conditions. It is utterly unacceptable. “System flow and capacity pressures continue to impact urgent and emergency care performance, with A&E performance below target and 12-hour waits remaining significantly above plan, driven by delayed discharges and constrained inpatient capacity.” Cheshire and Merseyside ICB continues to underperform against the A&E 4-hour standard and remains challenged by high levels of 12-hour waits from arrival, reflecting ongoing flow and discharge pressures across the urgent and emergency care pathway. • A&E 4-hour performance is 73.2% against the 78.2% target. While performance has remained relatively stable over the past 12 months and is marginally above the regional average (72.9%), it remains below the national ambition. A key constraint is system flow, with 20.2% of beds occupied by patients who no longer meet the criteria to reside, reducing capacity for emergency admissions and slowing movement through Emergency Departments. • A&E 12-hour waits from arrival remain a significant concern at 17.3% against a target of 15.6%. Performance demonstrates sustained special cause variation since late 2025, indicating a systemic issue rather than short-term fluctuation. The main drivers are limited inpatient capacity, discharge delays, and increasing complexity of frailty and urgent care demand Based on current performance, delivery of the 78.2% A&E 4-hour standard is unlikely in the short term, however, further incremental improvement is anticipated as discharge performance and bed utilisation improve. • Recovery in 12-hour waits is expected to be slower, given the scale of the challenge and its dependence on sustained improvements in inpatient capacity, discharge timeliness, and reductions in delayed discharges. Achievement of the target is dependent upon significant reductions in bed occupancy and frailty-related demand pressures “20.2% of beds occupied by patients who no longer meet the criteria to reside,” This can no longer be an excuse. If there is no capacity outside the NHS to address this issue the NHS will need to continue to adapt to this situation while still providing safe care. It must be possible to stop these long waits, corridor care and boarding in which have gone on throughout the summer of 2026 and for years before this.	Felicity Dowling

A visitor to Liverpool having had an awful long night in A and E with a family member commented at how calm it was. He said he did not think people in other parts of the country would tolerate that situation. We need urgent action on this.	

Response

Our urgent and emergency care offer is currently not meeting the needs of our populations. We remain focussed on whole system improvements involving all partners in each of our localities – primary care, community teams, social care colleagues and our acute hospitals. Our ambition in our strategy is to have a 'home first' approach, manage urgent need across communities and ensure our hospitals are available for true emergencies. In our preparations for Winter and beyond, we have invested in our urgent community response and care co-ordination, we are working with system partners on plans to improve care for Frail elderly patients and to ensure patients can also access our urgent care centres for a range of minor illness and injuries. We will be testing our plans as a system in September and mobilising new offers over the next few months.

Published: ***(31 July 2026)***