NHS
Cheshire and Merseyside

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

26 November 2026
13:00pm

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



Compassionate Inclusive Working Together Accountable

Leading integration through collaboration

Public Notice:

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

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

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

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

Raising Questions:

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

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

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

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

Additionally, these questions will also published on the ICB website.

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

Agenda

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
13:00pm	**Preliminary Business**				
ICB/11/26/26/01	Welcome, Apologies and confirmation of quoracy	Verbal	**Sir David Henshaw** *ICB Chair*	For information	-
ICB/11/26/26/02	Declarations of Interest *(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published on the ICB website)*	Verbal		For assurance	-
ICB/11/26/26/03	Minutes of the previous meeting: • 24 September 2026	Paper		For approval	Page 6
ICB/11/26/26/04	Board Action Log	Verbal			
ICB/11/26/26/05	Key issues – significant items to raise	Verbal		For discussion	-
ICB/11/26/26/06	Chairs announcements	Verbal		For information	-
ICB/11/26/26/07	Questions received from members of the public	Verbal		For information	-
ICB/11/26/26/08	Experience / achievement story	Film		For information	-
13:25pm	**ICB Business Items**				
ICB/11/26/26/09 **40 minutes**	Maternity Review • Engagement Report on proposed changes to where high risk and complex gynecology and maternity care takes place in Liverpool • Update on progress of delivery of safety improvements at Liverpool Womens Hospital • Update on National Maternity Reviews • Cheshire and Merseyside Maternity Services review	Paper Presentation on the day Paper Paper	**Dr Fiona Lemmens** *Executive Clinical Director*	For endorsement and noting	Page 16 Page 96 Page 105
ICB/11/26/26/10 **14:05pm** **25 minutes**	C&M Public Involvement Framework and Public Involvement Plan	Paper	**Ben Vinter** *Executive Director of Corporate Services and Governance*	For approval	Page 119
ICB/11/26/26/11 **14:30pm** **15 minutes**	Governance Handbook including • Committee Terms of Reference	Paper	**Ben Vinter**	For approval	Page 202

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
	• New Committee establishment – People and Culture Committee • Operational Scheme of Reservation and Delegation (OSoRD)		*Executive Director of Corporate Services and Governance*		
ICB/11/26/26/12 **14:45** **15 minutes**	Risk Management Strategy	Paper	**Ben Vinter** *Executive Director of Corporate Services and Governance*	For approval	Page 313
ICB/11/26/26/13 **15:00pm** **15 minutes**	Research & Innovation (R&I) Annual Update	Paper	**Dr Fiona Lemmens** *Executive Clinical Director*	For endorsement	Page 353
ICB/11/26/26/14 **15:15pm** **10 minutes**	Liverpool City Region (LCR) Health and Wellbeing Partnership Board – Brief and Terms of Reference	Paper	**Ian Ashworth** *Director of Public Health*	For endorsement	Page 389
15:25pm	**Leadership Reports**				
ICB/11/26/26/15	Report of the ICB Chief Executive	Paper	**Liz Bishop** *Chief Executive*	For assurance	Page 397
ICB/11/26/26/16 **15.35pm**	Cheshire and Merseyside ICB and System Finance Report – Month Seven	Paper	**Andrea McGee** *Executive Director of Finance and Contracting*	For assurance	Page 408
ICB/11/26/26/17 **15:45pm**	Highlight report of the Chair of ICB Finance, Investment and Contracting Committee	Paper	**Mike Burrows** *Non-Executive Member*	For assurance	Page 416
ICB/11/26/26/18 **15:50pm**	NHS Cheshire and Merseyside Integrated Performance Report	Paper	**Jude Adams** *Interim Executive Director of Transformation & Strategy (Turnaround)*	For assurance	Page 424
ICB/11/26/26/19 **16:00pm**	Highlight report of the Chair of ICB Quality and Performance Committee	Paper	**Dr Naomi Rankin** *Partner Member*	For assurance	Page 478
ICB/11/26/26/20 **16:05pm**	Highlight report of the Chair of System Primary Care Committee	Paper	**Erica Morriss** *Non-Executive Member*	For assurance	Page 483
ICB/11/26/26/21 **16:10pm**	Highlight report of the Chair of Northwest Specialised Commissioning Committee	Paper	**Dr Ruth Hussey** *Non-Executive Member*	For assurance	**Paper not expected prior to publication of Board papers and will be circulated**

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
					separately if received
16:15pm	**Closing Business**				
ICB/11/26/26/22	Closing remarks and review/reflections of the meeting	Verbal	**Sir David Henshaw** *ICB Chair*	For information	-
ICB/11/26/26/23	Any Other Business	Verbal		For information	-
16:20pm	**CLOSE OF MEETING**				

Date and start time of future meetings

28 January 2027. 13:00 pm, Liverpool Suite, Holiday Inn, Lime Street, Liverpool, L1 1NQ

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

NHS
Cheshire and Merseyside

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

Held in Village Hotel, 110 Centre Park Square,
Village Hotel Warrington
Thursday 24th September 2026
14.15 – 16.15

Unconfirmed Minutes

ATTENDANCE	
Name	**Role**
Members	
Sir David Henshaw	Chair, Cheshire & Merseyside ICB (voting member)
Dr Liz Bishop	Chief Executive, Cheshire & Merseyside ICB (voting member)
Dr Ruth Hussey, CB, OBE, DL	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Erica Morriss	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Adam Irvine	Partner Member (Primary Care), Cheshire & Merseyside ICB, (voting member)
Dr Naomi Rankin	Partner Member (Primary Care) Cheshire & Merseyside ICB, (voting member)
Clare Watson	Executive Director of Health and Integrated Care Commissioning, Cheshire & Merseyside ICB (voting member)
Sue Lorrimer	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Mike Burrows	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Andrea McGee	Executive Director of Finance and Contracting, Cheshire & Merseyside ICB (voting member)
Andrew Lewis	Partner Member, (Local Authority) Cheshire and Merseyside ICB (voting Member)
Ben Vinter	Executive Director of Corporate Services and Governance, Cheshire and Merseyside ICB (voting member)
Tony Foy	Non-Executive Member, Cheshire and Merseyside ICB (voting Member)
Trish Bennett	Partner Member (NHS Trust), Cheshire and Merseyside ICB (voting Member)
Fiona Lemmens	Executive Clinical Director, Cheshire and Merseyside ICB (voting Member)
Hilary Garratt	Non-Executive Member, Cheshire & Merseyside ICB (voting member)

In Attendance	
Louise Barry	Chief Executive, Healthwatch Cheshire
Jude Adams	Interim Executive Director of Strategy and Transformation, Cheshire and Merseyside ICB
Kerry Lloyd	Chief Nursing Officer, Cheshire and Merseyside ICB
Ian Ashworth	Director of Population Health, Cheshire and Merseyside ICB
Sallyanne Hunter	Head of Corporate Support and Governance, Cheshire and Merseyside ICB
Dr Peter Chamberlain	Strategic Clinical Lead for Urgent and Emergency Care, Cheshire and Merseyside ICB
Claire James	Director for Mental Health, LD, Learning Disabilities and Neurodiversity, Cheshire and Merseyside ICB
Lisa Wainwright	Executive Assistant (note taker) Cheshire and Merseyside ICB
Louise Robson	Chair, Health Innovation North West Coast (regular participant)

Apologies	
Name	**Role**
Prof Paul Kingston	Chair of ICB Research and Innovation Committee, (regular participant)
Janelle Holmes	Partner Member (NHS Trust), Cheshire and Merseyside ICB (voting Member)
Del Curtis	Partner member (Local Authority) (voting member)

Agenda Item, Discussion, Outcomes and Action Points
Preliminary Business and meeting governance
CB/09/24/26/01 Welcome, Apologies and confirmation of quoracy
The Chair welcomed the Board to the NHS Cheshire and Merseyside Board meeting in public, apologies were noted, and it was confirmed that the Board was quorate.
ICB/09/24/26/02 Declarations of Interest
No declarations were recorded.
ICB/09/24/26/03 Minutes of the previous meeting: 30 July 2026
The minutes of the previous meeting held on 30th July 2026 were accepted and recorded as a true and accurate reflection of the meeting.
ICB/09/24/26/04 Board Action Log
The action log was reviewed and all actions were closed.

ICB/09/24/26/05 Key issues – significant items to raise

Thirlwall Inquiry

The Board reflected on the findings of the Thirlwall Inquiry, recognising the distressing nature of the report and the profound impact on the families who lost babies. The Board was assured that all 17 recommendations would be carefully reviewed, with particular attention given to strengthening safeguarding arrangements and improving bereavement care. Updates on progress against the Thirlwall Inquiry recommendations will be reported to the Board in due course.

Existing safeguarding oversight and Board development arrangements will be expanded to incorporate the Inquiry's recommendations. The Board noted the locally developed 'When a Child Dies' framework, which supports general practices in responding appropriately to families following the death of a child.

Martha's rule

The Board was advised of the expansion of Martha's Rule, which enables patients, families, carers and staff to escalate concerns when a patient's condition is deteriorating. This will be extended to emergency departments across all hospitals by March 2028, with the ICB working alongside providers to support implementation.

ICB/09/24/26/06 Chairs announcement

Board membership

The Board noted that Warren Escadale's term had been extended to the end of October 2026 to allow a partner-led recruitment process to be undertaken.

ICB/09/24/26/07 Experience / achievement story

The Board were presented with a video related to the Children, Young People Mental Health review and transformation plan following a discussion as noted within agenda item 8.

The Board noted that they welcomed the strong emphasis on co-production, and hearing directly from children and young people.

ICB Business Items

ICB/09/24/26/08 Children, Young People Mental Health Review of 2024-26 and CYP Mental Health Transformation Plan 2026-2027

The Board were referred to the paper contained within the meeting pack related to the Children, Young People Mental Health Review of 2024-26 and CYP Mental Health Transformation Plan 2026-2027.

A welcome was made to Claire James, the newly appointed Director for Mental Health, Learning Disabilities and Neurodiversity for NHS Cheshire and Merseyside.

Significant process was reported as -

- increased access to mental health support;
- the development of 24/7 crisis services;
- mental health response vehicles;

- improvements to eating disorder pathways;
- strengthened arrangements to support young people transitioning into adulthood.

The Board noted that approximately 39,500 children and young people are now accessing support. Waiting times remain challenging, particularly within neurodiversity services, although performance is improving. Approximately 38% of children and young people are seen within 4 weeks, compared with a stated national position of 24%. Work is under way to ensure that children and young people receive appropriate support while waiting for services.

Board members welcomed the plan but emphasised that future reporting should demonstrate the outcomes achieved for children and young people, rather than focusing predominantly on activity and access. It was advised that particular attention should be given to reducing inequalities, addressing variation between places, improving patient-reported and clinically reported outcomes, and demonstrating improvements in health and wellbeing.

The importance of considering mental and physical health together and ensuring a holistic approach involving general practice, education, SEND services, Family Hubs and other system partners was highlighted by the Board. It was noted that Mental Health Support Teams in schools are increasingly being targeted towards areas of greatest deprivation and need.

The Board was assured that a detailed implementation plan sits behind the public-facing document, with identified actions, responsible leads, timescales and measures of success.

The Board:

- **NOTED** the progress and achievements delivered through the Children and Young People's Mental Health Plan 2024–2026.
- **NOTED** the ongoing risks and challenges outlined within the report.
- **APPROVED** the Children and Young People's Mental Health Transformation Plan 2026–2027.
- **SUPPORTED** publication of both the 2024–2026 achievements summary and the 2026–2027 plan on the NHS Cheshire and Merseyside website.

ICB/09/24/26/09 Cheshire and Merseyside Winter Plan 2026-27, and UEC Deep Dive

A welcome was made to Dr Peter Chamberlain, the Strategic Clinical Lead for Urgent and Emergency Care for Cheshire and Merseyside ICB. Dr Chamberlain and Jude Adams presented the winter plan and UEC deep dive as contained within the meeting pack. Members were advised that performance remains a significant concern and that urgent and emergency care must be regarded as a whole-system responsibility, rather than solely an acute hospital issue.

The Board noted the impact of prolonged emergency department waits and delayed discharge on patient safety, dignity and outcomes. Approximately 1 in 5 hospital beds are reported to be occupied by a patient who no longer meets the clinical criteria to reside, representing around 25k bed days each month. Particular concerns were raised regarding longer waits experienced by people with mental health needs.

The urgent and emergency care strategy focuses on strengthening care co-ordination, increasing urgent community response capacity, embedding frailty and dementia approaches, improving personalised care planning and using risk stratification to identify patients requiring earlier intervention. The Board heard about opportunities to expand virtual wards and community-based services, enabling more people to receive appropriate care at home.

The Board noted that discharge and patient flow will be critical to winter resilience. Although improvements have been made in corridor care, ambulance handovers and discharge activity, further improvement is required. Reducing the number of patients with no criteria to reside was identified as a particular priority.

It was emphasised and acknowledged that workforce resilience is fundamental to winter capacity. Maintaining vaccination uptake amongst health and care staff and the wider population, particularly those most vulnerable to respiratory illness, was highlighted as an important preventative measure.

The Board challenged the system to move beyond analysis and identify practical levers capable of delivering measurable change this winter. Strengthening locality urgent and emergency care boards, implementing single points of access and working more closely with ambulance services were identified as immediate opportunities. Board members stressed the importance of meaningful involvement from general practice, primary care, local authorities, social care and community providers.

There was strong support for testing new approaches in selected localities, bringing operational leaders from different organisations together with shared responsibility for improvement. Cheshire West was identified as an existing example where local leaders are being empowered to address delayed discharge collectively. A further opportunity to test this approach within the more complex urban environment of Liverpool was supported, including work to strengthen reablement services.

The Board highlighted patient safety and avoidable harm as important measures of success and requested continued consideration of the effects of prolonged emergency department waits and healthcare-associated infections.

The significant improvement in the quality of data and analysis available to understand variation across the system was welcomed by the Board. However, it was clear that the next priority is implementation, using the intelligence available to identify opportunities for prevention, redirection and shifting care closer to home.

Overall, the Board supported the urgent and emergency care and winter planning approach and encouraged the executive team and system partners to test different ways of working, demonstrate tangible improvement over the winter period and share learning across Cheshire and Merseyside.

The Board:

- **NOTED** the current urgent and emergency care performance position.
- **ENDORSED** the principle that winter preparedness will be delivered through accelerated implementation of the Cheshire and Merseyside UEC strategy rather than through standalone winter initiatives.
- **SUPPORTED** the six-pillar winter focus approach.
- **NOTED** NHS England's feedback on the initial Winter Plan Board Assurance Statement (BAS) submission and the actions taken in response.
- **NOTED** the current Board Assurance Statement (BAS) position and remaining areas requiring further assurance before final submission, and delegate authority to the Chair & Chief Executive to sign off the final BAS for submission by 30 September 2026.
- **SUPPORTED** the governance arrangements through strengthened Locality UEC Boards, the Cheshire and Merseyside System UEC Board and the System Coordination Centre.

- **AGREED** to maintain executive oversight of identified patient safety and operational risks through the winter period.

Leadership Reports

ICB/09/24/26/10 Report of the ICB Chief Executive

The Board were referred to the Chief Executive Report contained within the meeting pack, noting that the management of change process for staff at Band 8B and below had concluded following approximately 2,000 pieces of feedback. Internal recruitment has commenced, with the next phase focused on embedding the new structures and teams across the organisation and with system partners.

Work to strengthen governance arrangements is continuing in response to the organisation's undertakings, with a comprehensive report and supporting documentation due to return to the Board in November 2026.

The Board welcomed significant investment in mental health services, including plans for 5 mental health neighbourhood centres and 3 mental health emergency department schemes, subject to the necessary approvals. These developments are expected to support the shift towards community-based care and improve services for people presenting with mental health needs.

Progress was also noted on a number of transformation programmes, including the WorkWell programme and a Cheshire and Merseyside-wide phlebotomy redesign intended to support primary care, community diagnostics and the management of long-term conditions.

Board members discussed the integrated referral model for elective care and sought assurance that clinical triage, advice and guidance and other referral mechanisms were appropriately aligned. Concerns were raised about inappropriate rejection or redirection of referrals potentially resulting in delays, repeat referrals and poorer patient experience. It was agreed that a more detailed review of the referral management system would be brought forward, including consideration of appropriate outcome measures and whether patients receive the right care first time. The importance of involving general practice in the design, implementation and evaluation of referral pathways was emphasised.

The Board NOTED the report of the ICB Chief Executive

ICB/09/24/26/11 Cheshire and Merseyside ICB and System Finance Report – Month Five

The Board received an update on the financial position at Month 5 as per the paper contained within the meeting pack. It was noted that the ICB remained on plan, and maintaining strong financial control was emphasised as essential to enabling investment in transformation and the shift of care towards prevention and community-based services.

Key financial pressures included a £2m adverse variance within mental health contracts, primarily associated with new ADHD providers entering the market, alongside increasing volumes and costs of mental health packages of care. Work is under way to manage these pressures through improved activity planning and internal controls.

Prescribing also remains a financial pressure, including additional costs arising where cheaper alternative medicines are unavailable. Further detailed work is being undertaken to understand and manage the underlying drivers.

The Board was advised that all required efficiency savings have now been identified. The apparent negative position relating to reserves was principally due to the timing of those savings and was expected to correct later in the year. The financial forecast provides confidence that the ICB can achieve a break-even position, although a number of risks remain and will continue to be closely monitored.

At a system level, the Board noted emerging financial pressures, with the Cheshire and Merseyside system reported as £24m behind plan. Members emphasised the interrelationship between financial and operational pressures, particularly within mental health, where delays in discharging clinically ready patients can result in greater use of costly independent sector placements.

The Board NOTED the ICB and system financial positions at the end of August and acknowledged the associated risks and mitigating actions.

ICB/09/24/26/12 Highlight report of the Chair of ICB Finance, Investment and Contracting Committee

The Board referred to the highlight report of the ICB Finance, Investment and Contracting Committee, noting that the financial forecast was robust, with identified risks being appropriately managed. The Committee continues to develop a more comprehensive understanding of the ICB's overall expenditure which includes increased scrutiny of specialised commissioning and regular reporting from the System Primary Care Committee.

Particular attention is being given to approximately £1.5b of expenditure on community and mental health services, much of which is currently managed through block contracts. Work is under way to improve understanding of the activity and services being delivered through these contracts and to determine whether resources could be used more effectively. The findings from this work will inform future budget setting, commissioning decisions and the ICB's wider financial strategy, with the aim of ensuring that expenditure is aligned with priorities and delivers best value for the population.

Overall, the Committee reported that it is receiving increasing assurance and greater transparency regarding the ICB's overall expenditure.

The Board NOTED the highlight report of the ICB Finance, Investment and Contracting Committee meeting

ICB/09/24/26/13 NHS Cheshire and Merseyside Integrated Performance Report

The Board noted the Integrated Performance report as contained within the meeting pack, noting that performance was improving across a number of areas, including mental health, planned care and urgent care, although several measures remain behind plan.

It was emphasised that greater assurance was required that current improvement actions would be sufficient to achieve year-end targets. A detailed review of the full scorecard will therefore assess the distance from plan, the additional actions required during the second half of the year, when improvements are expected to become evident and any associated financial implications.

The Board also discussed performance relating to non-elective frailty admissions and the importance of developing a more predictive approach, particularly in view of anticipated winter pressures. It was agreed that frailty performance and forecasting would be considered further

through the Quality and Performance Committee, with enhanced analysis to be reflected in future Board reporting.

The Board NOTED the contents of the Integrated Performance report and actions noted.

ICB/09/24/26/14 Highlight report of the Chair of ICB Quality and Performance Committee

The Board were referred to the highlight reports of the Chair of the Quality and Performance Committee, noting continued oversight of the National Paediatric Cardiology Improvement Programme. Concerns regarding compliance with the designated review process at one provider had been escalated to NHSE, resulting in the establishment of an ICB-led incident management group. Significant progress was reported, with issues expected to be rectified by the end of October.

The System Quality Group had focused on care home quality, identifying variation in community and primary care support, discharge communication and placement decisions. Concern was raised about the need for earlier identification of escalating care needs to prevent avoidable hospital admissions and inappropriate escalation to nursing care. Further work will be undertaken and reported through the Committee.

The Committee had also undertaken a strategic reset and identified 5 key areas of focus: maternity oversight, fragile services, mental health delays, variation in outcomes and the future approach to patient experience.

Overall, the Committee is seeking to move from a traditional provider-monitoring approach towards one that provides greater assurance and support for strategic commissioning and improved population outcomes.

The Board NOTED the highlight report from the Quality and Performance Committee

ICB/09/24/26/15 Highlight report of the Chair of the Audit Committee
• Audit Committee Annual Report

The Board were referred to the highlight report of the Chair of the Audit Committee and annual report as contained within the meeting pack. It was noted that the risk relating to compliance with governance, financial and operational policies remained rated red, reflecting its close connection with the NHSE undertakings. The rating will be reviewed at the Committee's next meeting.

A reduction in Freedom of Information compliance was reported, partly reflecting the impact of organisational change and challenges in obtaining information from across the organisation. Performance will continue to be monitored.

The Risk Management Strategy is currently under review and will return following the November Board meeting.

Positive progress was reported through the introduction of a Corporate Governance Handbook, representing an important element of the response to the NHSE undertakings. The Committee also highlighted progress on cyber security, with a collaborative approach being taken across health organisations in Cheshire and Merseyside.

The Board NOTED the highlight report from the Audit Committee and Annual Report.

ICB/09/24/26/16 Highlight report of the Chair of System Primary Care Committee

The Board were referred to the highlight report of the Chair of System Primary Care Committee contained within the meeting pack, noting that it had developed sufficient maturity to consider significant changes to locally enhanced services. The existing services and specifications will be reviewed and aligned with the 5-year commissioning plan, recognising that the changes may have differing impacts on individual GP practices. Further proposals are expected to return for consideration before December 2026.

The Board noted the results of the GP Patient Survey, which were generally positive. Whilst challenges remain around initial access and triage, patient experience was reported to be considerably more positive once patients were able to see a GP or other primary care professional. Further work will focus on understanding variation in patient experience and addressing inconsistencies across practices, with the aim of raising performance and improving access across the system.

The Board NOTED the highlight report of the System Primary Care Committee

ICB/09/24/26/17 Highlight report of the Chair of Northwest Specialised Commissioning Committee

The Board were referred to the highlight report from the Chair of the North West Specialised Commissioning Committee as contained within the meeting pack. It was noted that the development of the OPIC arrangements remains ongoing and that the September meeting of the Specialised Commissioning Committee had been cancelled, although an update had been provided.

Concern was raised regarding the need for clear governance and decision-making arrangements for OPIC, particularly as the proposed shadow arrangements were not expected to be operational by October. The Board discussed the need for further detail on how decisions will be made during the interim period, where accountability will sit until the new arrangements are established. The Board noted that it was now expected that arrangements would be brought forward by the November Board.

The Board NOTED the highlight report from the Chair of the North West Specialised Commissioning Committee.

ICB/09/24/26/18 Highlight report of the Chair of Remuneration Committee

The Board were referred to the highlight report for the Chair of the Remuneration Committee as contained within the meeting pack. It was noted that the Committee was assured by the quality of reporting and the processes followed throughout the organisational change programme. It recognised that some matters had required consideration at short notice but accepted that this had been necessary given the pace of change. Overall, the Committee remained supportive of the transformation process and would continue to provide oversight as the organisational changes progress.

The Board NOTED the highlight report of the Chair of Remuneration Committee

Closing Business

ICB/09/24/26/19 Closing remarks and review/reflections of the meeting

Members were thanked for their contribution

ICB/09/24/26/20 Any Other Business

Vaccination programme

Further to discussions on immunisations and vaccinations at the AGM preceding this meeting the Board received an update on the establishment of a weekly vaccination task force, bringing together partners from across the health and care system. The group will oversee vaccination uptake across all age groups, including patients, the public and health and social care staff, with a focus on flu, COVID-19, RSV and pneumococcal vaccinations.

The national flu vaccination target for healthcare workers was reported as 60%, with Cheshire and Merseyside setting a more ambitious local target of 70%. Progress will be monitored weekly, reported fortnightly to the Executive Committee and brought back to the Board in November 2026.

Blood shortages

The Board was alerted to the national shortage of blood stocks, particularly O negative and B negative blood, and the need to increase donations from people of Black heritage to support the treatment of sickle cell disease. Members, staff and the wider public were encouraged to donate blood where eligible.

CLOSE OF MEETING

Date of next meeting held in public

26 November 2026. 13:00am, Conference Suite, Riverside Innovation Centre, 1 Castle Drive, Chester, CH1 1SL

DRAFT

Meeting of the Board of NHS Cheshire and Merseyside

26 November 2026

Engagement Report on proposed changes to where high risk and complex gynaecology and maternity care takes place in Liverpool

Agenda Item No: ICB/11/26/26/09

Responsible Director: Fiona Lemmens, Executive Clinical Director

REPORT SUMMARY SNAPSHOT

Required Information	Details			
Responsible Executive Director	Fiona Lemmens, Executive Clinical Director			
Report approval	**By**	*Fiona Lemmens*		
	Date	*26.10.26*		
Presented by	*Fiona Lemmens*			
Ask of the Board	**Approval**		**Decision**	
	Endorsement	✓	**Ratification**	✓
	Receive assurance	✓	**Note**	
Route to Board – where has this report been discussed	*Executive Committee 12.11.26*			
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 P14 Failure to Recover Access and Performance Standards			
Financial Implications*	**Yes**	✓	**No**	
	If Yes:			
	Have the financial implications been reviewed by the Director of Finance	✓		
	Has a budget been identified	✓		
Legal Implications*	*n/a*			
Conflicts of Interest associated with this report	*n/a*			
Impact assessments undertaken*	**Equality**	✓		
	Quality	✓		
	Data	✓		
	Sustainability	✓		
Public or Clinical engagement undertaken	*Both public and clinical engagement has been undertaken on this programme of work – but this item specifically pertains to the latest phase of public engagement (summer 2026)*			

Engagement Report on proposed changes to where high risk and complex gynaecology and maternity care takes place in Liverpool

1. Purpose of the Report

The purpose of this paper is to present an independent engagement report which summarises the findings of a six-week public engagement process on proposed changes to where high risk and complex maternity and gynaecology care in Liverpool takes place, which ran between 2 June – 14 July 2026.

2. Ask of the Board and Recommendations

The Board is asked to:

- Read and review the engagement report (included as an Appendix to this paper)
- Discuss and consider the next steps for the provider Trust (University of Liverpool Hospitals Trust) to take these findings forwards

3. Background

On 29 January 2026, the Board of NHS Cheshire and Merseyside ICB agreed to progress with a medium-term service development proposal to improve hospital gynaecology and maternity services in Liverpool.

This proposal (known as ‘Option 2’ in the appraisal process) involves moving complex and high-risk gynaecology and maternity procedures from Liverpool Women’s Hospital to the Royal Liverpool Hospital to improve the safety and quality of this care for a small cohort of patients (around 1% of all care).

NHS Cheshire and Merseyside agreed to undertake a six-week public engagement as part of the development process for this improvement work, which took place between 2 June – 14 July 2026.

4. Legal context for involvement

Both integrated care boards (ICBs) and NHS trusts have a legal duty to involve the public in service change processes as set out in the National Health Services Act 2006 and Health and Care Act 2022.

Although this service change proposal did not meet the threshold for requiring a formal consultation process given the relatively small scale of the change and numbers of patients impacted by the proposal, in recognition of the high levels of public interest in these services

and as part of a continued commitment to transparency, in January 2026 the Board committed to undertaking further engagement.

The purpose of this was to:

- better understand the views of patients, staff, stakeholders and local communities about this proposal
- identify and mitigate against any unforeseen impacts for those patients affected
- help inform the development of a business case for the proposal by the provider.

5. About the engagement process

A range of methods were used to support people to share their views during the six-week process, including:

- a questionnaire (online and print)
- public information events (held in Liverpool, Knowsley and Sefton)
- one-to-one in-depth interviews/conversations with people who had lived experience of receiving high risk or complex care (including those who transferred between hospitals or were at high risk of needing a transfer)
- opportunities for discussion at existing community meetings and networks
- social media
- telephone or email contact

The engagement was also supported by a Lived Experience Panel comprising of people with experience of using hospital gynaecology and maternity services in Liverpool, either as patients, carers or family members.

6. Report findings

The purpose of the engagement report (available as an appendix) is to present an independent analysis of the feedback received during the engagement period. These findings were analysed and summarised into a report by specialist external analysts, Hood and Wolf.

The report does not seek to make recommendations or reach conclusions about the proposal. Instead, it provides an objective summary of the views, experiences, concerns and suggestions shared by participants. Key findings were as follows:

- Nearly two-thirds of respondents (62%) agreed with the proposed changes, including 40% who strongly agreed.
- In comparison, 29% disagreed with the proposal.
- A further 7% neither agreed nor disagreed.

Although there was overall agreement with the proposal across all groups, agreement levels were notably higher amongst the following groups:

- respondents whose family members/friends had directly experienced unplanned transfers of care between the hospitals - 78% agreed or strongly agreed

- healthcare and social care professionals - 72% agreed or strongly agreed

The most commonly cited reason for agreeing with the proposal was improving access to specialist acute and critical care services. Respondents also frequently highlighted the importance of patient safety, access to specialist expertise, and reducing the risks associated with emergency transfers between hospital sites.

A significant minority of respondents also expressed some concerns about the proposal, which focused on the future of Liverpool Women's Hospital, whether more investment should instead be directed towards the existing hospital, and the capacity and suitability of the Royal Liverpool University Hospital.

7. Next steps and responsibilities

The full report and a summary version will be published on the ICB's website and proactively shared with key stakeholders.

The findings presented in this report will be shared with the provider Trust to help inform further development work on the next steps, and will be considered alongside other evidence, including clinical, operational, financial, and equality impact assessments.

8. Officer contact details for more information

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Appendices

Appendix 1: Full engagement report

HOOD & WOOLF

Improving Hospital Gynaecology and Maternity Services in Liverpool: Proposed changes to where high risk and complex care takes place

Engagement report for NHS Cheshire and Merseyside Integrated Care Board

October 2026

Hood & Woolf Ltd.

Golden Cross House
8 Duncannon Street
London, WC2N 4JF

Any press release or publication of the findings of this report requires the advance approval of Hood & Woolf. Such approval will only be refused on the grounds of inaccuracy or misrepresentation.

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Executive summary

NHS Cheshire and Merseyside undertook a six-week public engagement between 2 June and 14 July 2026 regarding a proposal to move a small number of high-risk births and complex gynaecology procedures from Liverpool Women's Hospital to the Royal Liverpool University Hospital. The proposal forms part of the wider Women's Hospital Services in Liverpool programme, which is reviewing how hospital maternity and gynaecology services are organised in Liverpool.

The proposal is to improve access to specialist acute, emergency and critical care services for women with the most complex care needs. If implemented, the proposal would affect approximately 150 women each year, representing around 1% of maternity and gynaecology activity currently undertaken in Liverpool.

As part of the proposal, there would also be better specialist support at Liverpool Women's Hospital and more specialist gynaecology and maternity support for the emergency department teams at both the Royal Liverpool Hospital and Aintree Hospital.

During the engagement period NHS Cheshire and Merseyside sought to gather views from patients, carers, NHS staff, stakeholders and local communities before any decisions are made. People were invited to provide feedback on the proposals through a range of channels, including questionnaire, email and telephone contact. Opportunities were also provided for people to discuss the proposals and complete the questionnaire at public information events and community and stakeholder network meetings. In addition, one-to-one interviews were undertaken.

This report presents an independent analysis of the feedback received during the engagement period.

Overview of who responded

A total of 430 questionnaire responses were received during the engagement period. In addition, four one-to-one interviews were undertaken with women who had lived experience of complex maternity and gynaecology care in Liverpool.

Just over half of questionnaire respondents (52%) lived in Liverpool, with further responses received from Sefton (16%), Knowsley (10%) and other areas across Cheshire and Merseyside and further afield. Just under half of respondents (49%) identified themselves as working in healthcare or social care, although many shared experiences as patients, carers or family members, as well as professional perspectives.

Respondents represented a broad range of ages and backgrounds. The majority were female (81%), reflecting the focus of the services under consideration. A total of 9% of respondents were pregnant at the time of the survey and 5% had given birth within the previous six months.

Many respondents had direct experience of hospital maternity and gynaecology services in Liverpool. Overall, 43% reported having used hospital gynaecology services, while 37% had used hospital maternity services. Just under one in five respondents also reported direct or indirect experience of transfer of care between hospitals because specialist or emergency support was required.

People's views on the proposed changes

Overall, respondents were more likely to agree with the proposal than disagree with it. Nearly two-thirds of respondents (62%) agreed with the proposed changes, including 40% who strongly agreed. In comparison, 29% disagreed with the proposal and 7% neither agreed nor disagreed.

Support for the proposal was evident across respondent groups. A majority of non-professional respondents agreed with the proposed changes (54% overall, comprising 32% who strongly agreed and 22% who agreed). Agreement with the proposal was higher amongst healthcare and social care professionals, with 72% agreeing overall (50% strongly agreed and 22% agreed), and respondents whose family members or friends had experienced unplanned transfers of care between hospitals, where 78% agreed overall (69% strongly agreed and 9% agreed). These respondents frequently highlighted the importance of patient safety, access to specialist expertise and reducing the risks associated with emergency transfers between hospital sites.

Overall, the most commonly cited reason for agreeing with the proposal was improving access to specialist acute and critical care services. Many respondents felt that women with the most complex healthcare needs should receive care in environments where specialist teams, critical care services and additional clinical expertise are immediately available.

However, a substantial minority of respondents expressed concerns about the proposal. Common concerns included the future of Liverpool Women's Hospital, whether investment should instead be directed towards the existing hospital, the capacity and suitability of the Royal Liverpool University Hospital, and the potential impact on women, babies and families.

Respondents who were currently pregnant, had recently given birth, or had direct experience of maternity services were generally less likely to agree with the proposal. These respondents were more likely to emphasise the value of the specialist

environment at Liverpool Women's Hospital, raise concerns about mothers and babies being separated, and highlight the importance of maintaining family-centred care.

The interviews undertaken with women who had experienced complex maternity and gynaecology care in Liverpool reinforced themes identified through the wider engagement. Participants described the emotional impact of transfers between hospitals, separation from family members, communication between organisations and the need for improved follow-up support.

Across all sources of feedback, there was a strong and consistent emphasis on maintaining safe, high-quality care for women and babies. While views differed on the best way to achieve this, respondents consistently highlighted the importance of patient safety, access to specialist expertise, communication, continuity of care and ensuring that the needs of women and their families remain central to future decision-making.

1 Introduction

NHS Cheshire and Merseyside has been reviewing how hospital gynaecology and maternity services are organised in Liverpool to address a number of long-standing challenges affecting the delivery of care.

This work is being led through the Women's Hospital Services in Liverpool programme, in close partnership with University Hospitals of Liverpool Group, which manages Aintree University Hospital, Broadgreen Hospital, Liverpool University Dental Hospital, Liverpool Heart and Chest Hospital, Liverpool Women's University Hospital and the Royal Liverpool University Hospital.

Currently, most hospital gynaecology and maternity services are provided at Liverpool Women's Hospital. Women's services in the city are arranged differently to those in the rest of England. In other parts of the country, specialist centres for gynaecology and maternity care are located alongside acute and emergency hospital services.

In Liverpool, these services are delivered separately from other acute adult services, including critical care and a range of specialist and emergency services. NHS Cheshire and Merseyside has identified that this arrangement can create challenges in providing timely access to specialist support for women with complex health needs and can increase the risks associated with transferring seriously ill patients between hospitals.

NHS Cheshire and Merseyside is seeking to identify a long-term solution that will improve the quality, safety and sustainability of hospital gynaecology and maternity services for everyone who uses them. However, recognising that broader solutions would require significant investment and take time to develop, a smaller-scale change is being proposed to improve care for women with particularly complex or high-risk conditions.

The proposal at the centre of this engagement was for a small number of high-risk births and complex gynaecology procedures to take place at the Royal Liverpool University Hospital rather than Liverpool Women's Hospital. If implemented, the proposal would affect approximately 150 women each year, representing around 1% of the maternity and gynaecology activity currently provided in Liverpool. Most maternity, gynaecology and neonatal services would continue to be delivered at Liverpool Women's Hospital, supported by additional funding for extra staffing and resources for improving the quality and safety of services across both hospital sites.

To understand the views of patients, staff, stakeholders and local communities, NHS Cheshire and Merseyside undertook a six-week public engagement between 2 June and 14 July 2026. The purpose of the engagement period was to provide information about the proposal, explain the reasons for change and give people an opportunity to share their views before any decisions are made.

A range of methods were used to support participation, including a questionnaire, public information events, one-to-one interviews with people who had lived experience

of complex maternity and gynaecology care in Liverpool, email and telephone contact routes, and opportunities for discussion through community and stakeholder networks. Public events and discussions with community groups were primarily used to raise awareness of the engagement period, provide information about the proposals and encourage participation by completing the engagement questionnaire. Information was made available through a dedicated programme website, printed materials, partner organisations and wider communications activity.

The engagement was also supported by a Lived Experience Panel comprising people with experience of using hospital gynaecology and maternity services in Liverpool, either as patients, carers or family members. Panel members provided valuable input into options development workshops, as well as the development of engagement materials and helped ensure that information was accessible and understandable for members of the public.

This report presents an independent analysis of the feedback received during the engagement period. It draws on questionnaire responses, interviews, feedback received through correspondence, and other feedback routes between June and July 2026.

The report does not seek to make recommendations or reach conclusions about the proposal. Instead, it provides an objective summary of the views, experiences, concerns and suggestions shared by participants.

The findings presented in this report will be considered alongside other evidence, including clinical, operational, financial and equality impact assessments, to inform future decision-making regarding the proposed changes.

A note on language and report conventions

It's not only people who identify as women (or girls) who use women's health services. Throughout this report, the terms 'woman' and 'women's health' are used in line with the terminology adopted by NHS Cheshire and Merseyside, who use these terms to include trans men and non-binary individuals assigned female at birth who also access these services.

To provide additional context, where differences between subgroups of respondents are highlighted in the report, an asterisk (*) is used to identify findings relating to small subgroups of 20 or fewer respondents.

Thank you

NHS Cheshire and Merseyside would like to thank everyone who took the time to share their views during the engagement period.

2 An overview of this engagement

2.1 Promotion to patients, people and communities

A comprehensive programme of communications and engagement activity was delivered to raise awareness of the engagement and encourage participation from patients, people and communities across Liverpool, Knowsley, Sefton and the wider Cheshire and Merseyside area. This approach was informed by the programme's communications and engagement plan, which set out a commitment to using a range of communication and engagement methods, accessible formats and existing community networks to ensure that people had opportunities to understand the proposal and share their views.

Pre-engagement planning

Prior to the launch of the engagement, NHS Cheshire and Merseyside developed a detailed communications and engagement plan setting out the approach to engaging patients, the public, staff, stakeholders and communities. The plan was reviewed through a number of governance and stakeholder groups, including the Communications and Engagement Reference Group, the Lived Experience Panel and NHS partners.

Website

A dedicated programme website – www.GynaeandMaternityLiverpool.nhs.uk – was used as the central source of information throughout the engagement period. The website hosted information about the proposal, supporting documents, details of public information events and information about how to provide feedback. The website was promoted throughout the engagement and was referenced in all communication materials and media activity.

During the engagement period, the programme website recorded 2,515 home page views. In addition, NHS Cheshire and Merseyside's website news articles relating to the engagement recorded a total of 92 page views and 71 individual visitors, while the landing page recorded 23 link clicks.

Engagement materials

A range of engagement materials were developed to support the process, including a detailed information booklet, summary materials, posters, leaflets, presentation materials and digital resources. Accessible versions of key materials were also produced, including Easy Read and British Sign Language resources, with additional formats and translations available on request.

During the engagement period, requests were received for materials in Arabic, Kurdish and large print formats.

Communications toolkit

A communications toolkit was developed and distributed to a broad range of partner organisations to support promotion of the engagement through established networks and communication channels. Recipients included NHS provider trusts, Healthwatch organisations, local authority communications teams, CVS organisations, Patient Participation Groups, Patient Voice Representatives, Liverpool Maternity and Neonatal Voices Partnership, specialist women's health networks and a range of voluntary and community organisations.

The toolkit included communication materials, key messages, website content, social media assets and links to engagement resources to support consistent communication about the proposals.

Information about the engagement was also distributed directly to established stakeholder networks, including 24 members of the Lived Experience Panel, 494 members of the Community Voices network and 73 members of the Virtual Reference Group.

Attendance at external meetings and events

Alongside the formal engagement activities, information about the proposals was shared through a number of existing stakeholder and community meetings. Presentations and briefings were delivered to:

- Communications Reference Group (5 May 2026)
- Lived Experience Panel (6 May 2026)
- Local MPs briefing session (20 May 2026)
- Cheshire West Collaborative (9 June 2026)
- SPACE Network (17 June 2026)
- Standing Together event hosted by Sefton CVS (24 June 2026)
- Sefton People and Communities Group (24 June 2026)
- Liverpool Maternity and Neonatal Voices Partnership (25 June 2026)

The local MPs briefing session was attended by representatives from the offices of Kim Johnson, Ian Byrne, Peter Dowd, Paula Barker and Maria Eagle.

These meetings provided opportunities to explain the proposals, answer questions and encourage participation through established stakeholder and community networks.

Media promotion

The engagement was promoted through a comprehensive programme of media activity. Coverage was achieved through a range of local, regional and partner media channels, including the NHS Cheshire and Merseyside website, ITV News, BBC News, BBC North West Tonight, BBC Radio Merseyside, Knowsley News, Liverpool Express, The Clatterbridge Cancer Centre, Liverpool Hospitals Group, Healthwatch Liverpool, Healthwatch Sefton, Global Radio, Knowsley Healthwatch and the Liverpool Echo.

Media interviews were also undertaken to support awareness of the engagement period, including coverage on BBC North West Tonight and a Global Radio interview.

Social media promotion

Social media was used throughout the engagement period to raise awareness of the proposals and signpost people to further information and opportunities to participate. A total of 26 posts were published across Facebook, Instagram, X and LinkedIn. These generated 9,566 impressions, 381 engagements and 24 click-throughs to the engagement website.

2.2 Promotion to NHS staff

Information about the engagement was shared with NHS staff through existing communications channels across NHS Cheshire and Merseyside and partner organisations. Briefings were distributed through NHS trust communications teams, NHS Cheshire and Merseyside internal communications, general practice newsletters and wider NHS stakeholder communication routes. Staff working within maternity and gynaecology services also received information through dedicated organisational communication channels.

2.3 Methods of providing feedback

The engagement was designed to provide a range of opportunities for people to share their views in ways that were accessible and convenient to them. The primary method of feedback was an online questionnaire, supported by paper copies and alternative formats available on request.

Three public information events were held during the engagement period in Sefton, Knowsley and Liverpool. These events provided an opportunity for people to hear more about the proposal, ask questions and receive support to complete the questionnaire if required.

In addition, four individual interviews were undertaken with women who had lived experience of the complex maternity and gynaecology care that forms the focus of the proposal. These interviews provided an opportunity to gather more detailed qualitative feedback from people directly affected by the services under consideration.

People were also able to provide feedback through email, correspondence and telephone contact. Dedicated email and telephone contact points were available throughout the engagement period to enable people to seek information, request materials in alternative formats and provide feedback on the proposals.

3 Questionnaire methodology

3.1 Questionnaire design

The questionnaire aimed to enable people to share their views on the proposal to move a small number of the most high-risk and complex maternity and gynaecology services from Liverpool Women's Hospital to the Royal Liverpool University Hospital, as well as any experiences relevant to the proposal.

No questions were mandatory, which meant that participants could choose not to answer any that didn't apply to them, or where they did not want to provide feedback.

The questions were carefully selected to generate a range of both quantitative and qualitative feedback.

The quantitative data provides a basis for numerical comparison, while the qualitative feedback, such as people's thoughts and experiences, provided an opportunity to understand people's views and experiences in their own words. The qualitative responses were analysed to identify any key themes across all the responses and use anonymised direct quotations of people's specific feedback to highlight themes, opinions, and views.

The qualitative feedback was analysed using a structured thematic coding approach. The themes that emerged from this analysis are presented with the most commonly mentioned first, within the relevant sections of this report.

The main body of the questionnaire asked respondents about the proposal, including the extent to which they agreed or disagreed with it, any impacts they believed should be considered, their experiences with maternity and gynaecology services, and any experiences of planned or emergency transfers between hospitals.

The remainder of the questionnaire was dedicated to asking respondents about themselves, for example whereabouts they lived and where they worked (if they were a healthcare or social care professional).

The final section contained equalities monitoring questions. These ask about people's characteristics (such as their age, gender, religion, relationship status, and if they have any disabilities). This information has been used to help understand who responded to the engagement, and whether views differed between groups.

In order to measure the effectiveness of promotional activity, identify any gaps in responses, and ensure that responses were received from a diverse range of people, a mid-point review was built into the engagement period. As a result of this, a number of actions were put in place, including targeting of specific groups, both using social media and through promotion to relevant organisations and community networks.

4 Responses and findings from the questionnaire

4.1 Overview of who responded

Number of responses

During the engagement period, 430 people completed a questionnaire in order to share their views.

Of the respondents, 209 indicated that they were a healthcare or social care professional – although they did not necessarily work in or alongside gynaecology or maternity services, and many completed the questionnaire to share their experiences of having been a patient.

Four people who completed the questionnaire ticked the box to say they were responding on behalf of an organisation but then gave no further details indicating the name or type of organisation. We have included these responses, but they have been treated as responses from individuals.

A full breakdown of the demographic information for questionnaire respondents can be found in Appendix A. This also includes how people found out about the questionnaire, and the level of engagement material they had read before responding.

Key demographic information

Where people live

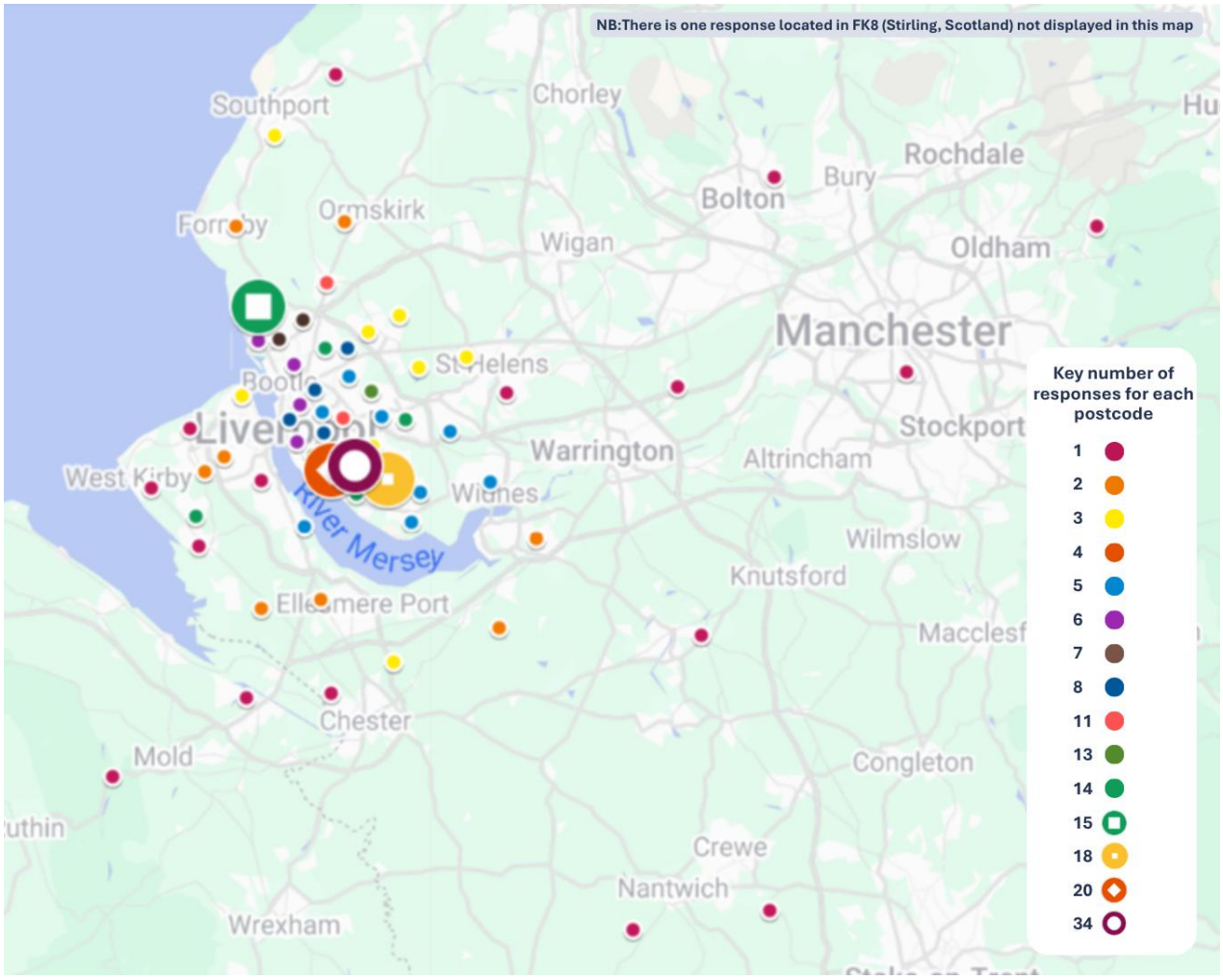

Figure 1: What is the start of your postcode?

Just over half of respondents – 52% – lived in Liverpool, while 16% lived in Sefton, 10% in Knowsley, and 7% in Wirral. Smaller proportions lived in Cheshire West, St Helens, Halton, Cheshire East, and Warrington (each with 3% or less).

Ethnicity

Among those who provided information on ethnicity, the majority identified as White (85%). The majority were English / Welsh / Scottish / Northern Irish / British, who accounted for 81% of respondents (see Appendix A, Chart 3).

Among survey respondents, those from other ethnic backgrounds represented a relatively small proportion, those from Mixed / Multiple ethnic groups (3%), Asian backgrounds (2%), Black / African / Caribbean / Black British backgrounds (1%) and Arab backgrounds (less than 1%).

Age

The largest proportion of respondents was aged between 30 – 49 (48%), with 36% aged 50 or older and 9% under 30.

Gender

In terms of gender, the majority of respondents identified as female (81%), with 12% identifying as male. A small number identified as non-binary and gender-non-conforming, while 3% preferred not to say.

Pregnancy and recent birth

Pregnancy and childbirth data showed that 9% of respondents were pregnant at the time of the survey, and 5% had given birth within the past six months.

Healthcare or social care professionals

49% of respondents indicated that they worked in healthcare or social care, although they did not necessarily work in or alongside gynaecology or maternity services, and many shared their experiences of being a patient.

A full breakdown of the demographic information for questionnaire respondents can be found in Appendix A.

4.2 Experience with Liverpool Maternity and Gynaecology Services

As part of the questionnaire, respondents were asked whether they, someone close to them, or both, had used hospital maternity and/or gynaecology services in Liverpool. They could select multiple options to reflect their own experiences, those of close family members or friends, and/or whether they worked in or alongside these services. Responses to this question were broken down as follows:

- 43% reported that they had used hospital gynaecology services
- 37% reported that they had used hospital maternity services
- 23% reported that someone close to them had used hospital gynaecology services
- 24% said that someone close to them had used hospital maternity services
- 15% reported working in or alongside hospital gynaecology and maternity services
- 11% wanted to share their views despite not having personal or close contact with these services.

A further 1% indicated they were responding on behalf of an organisation, however they did not provide details when prompted. Their responses have been treated as being from an individual and included in the analysis. While 3% of respondents did not complete this question.

4.3 Experience with transfer of care

Respondents were asked whether they, or someone close to them, had experienced a transfer of care from Liverpool Women's Hospital to another hospital because more specialist or emergency care was required. They could select multiple options to reflect both their own experiences and those of close family members or friends.

The majority of responses (77%) indicated that neither they nor someone close to them had experienced a transfer of care because more specialist or emergency care was needed.

Around one in five respondents (19%) reported some experience of a transfer of care, either directly or through someone close to them, broken down as follows:

- 4% reported they had experienced a planned move of care
- 3% reported they had experienced an emergency or unplanned move of care
- 6% reported that someone close to them had experienced a planned move of care
- 7% reported that someone close to them had experienced an emergency or unplanned move of care

A further 2% of respondents were not sure whether they or someone close to them had experienced a transfer of care, while 2% did not provide a response to the question.

Respondents who had experience of transfer of care were invited to describe that experience, including anything that worked well or could have been improved. Among this group, the most common themes related to availability of specialist services (25%), transfer process and logistics (24%), and quality and safety of care (24%). Other themes included the emotional impact of transfer (21%) and communication and coordination (18%). A substantive answer was not provided by 39% of respondents with experience of transfer of care. Further detail on these responses is provided below.

Availability of specialist services

The most common theme among responses from those with experience of transfer of care related to the availability of specialist services, featuring in 25% of responses.

> *"Having the expertise of the right people made all the difference and having to travel to a different hospital could have been catastrophic but thankfully wasn't."*

> *"They were cared for at the highest level in Manchester, but that level of care should have been available in Liverpool, it is a big enough city."*

Transfer process and logistics

Transfer process and logistics featured in 24% of responses from respondents with experience of transfer of care.

> *"Transferred in emergency conditions from [the] Women's to Royal then back to Women's [Hospital]. Then to Royal then to Wythenshawe.... Was a disaster."*

> *"Putting her in a taxi with drains in to go to the Royal for other treatment with non-qualified staff was very unsatisfactory. It ran a high risk of infection."*

> *"They were kept informed of what was happening, but they waited an hour for an ambulance. That was an hour that could have been avoided if they had been at the Royal."*

Quality and safety of care

Quality and safety of care was also identified in 24% of responses from respondents with experience of transfer of care.

> *"Post fall I had an emergency transfer to the Royal for a head CT. I was treated effectively and efficiently by all."*

> *"Poor communication, time delays and unsafe patient care."*

> *"I was transferred to the Royal and underwent a hysterectomy that was high risk there due to a bleeding disorder. I felt this was the safest option for me. Surgeons from the Women's did the procedure and post op I was cared for on HDU."*

Emotional impact of transfer

The emotional impact of transfer featured in 21% of responses from respondents with experience of transfer of care.

> *"Being separated from the baby was horrific."*

> *"[A family member] developed [a rare condition] and required an ITU bed, as this was not pre planned/arranged there was no bed available locally, she needed to be transferred to Macclesfield, leaving her partner and newborn behind in Liverpool, which was very stressful and upsetting for everyone."*

> *"Although it was for safety and necessary. The woman felt alone, isolated and scared being in an unknown city (Salford). It would be better to have a plan and be closer to home."*

Communication and coordination

Communication and coordination was identified in 18% of responses from respondents with experience of transfer of care.

> *"The lack of cohesiveness between the systems was very clear. It made my family lose confidence in the treatment, my mum became unwell and now has a life changing condition due to being missed between the two systems. Each organisation kept blaming the other and telling her to phone the opposite side, which really wasn't her responsibility to do."*

> *"The reasons were poorly communicated, the follow-up on the ward was poor as the specialists were not all based there and the information on discharge was confusing."*

> *"Both my family members had their care planned/managed through MDT [Multidisciplinary Team] discussions across two hospital sites. Their admissions were planned at Aintree and the RLH [Royal Liverpool Hospital] involving the colorectal team. One family member required further management due to some nerve damage which was more readily available due to being at the RLH post op and not at LWH [Liverpool Women's Hospital]."*

4.4 Agreement on the proposed change

Respondents were asked the extent to which they agreed or disagreed with the proposal to move a small number of the most high-risk and complex births and gynaecology operations from Liverpool Women's Hospital to the Royal Liverpool University Hospital. The proposed change is intended to improve access to specialist acute and emergency care and is expected to affect around 150 women each year.

Overall, over six-in-ten respondents (62%) agreed with the proposal, including 40% who strongly agreed and 22% who agreed. In contrast, 29% disagreed with the proposal, including 17% who strongly disagreed and 12% who disagreed. A further 7% neither agreed nor disagreed, while very few respondents selected "don't know" (1%), 2% did not provide an answer (see Chart 1).

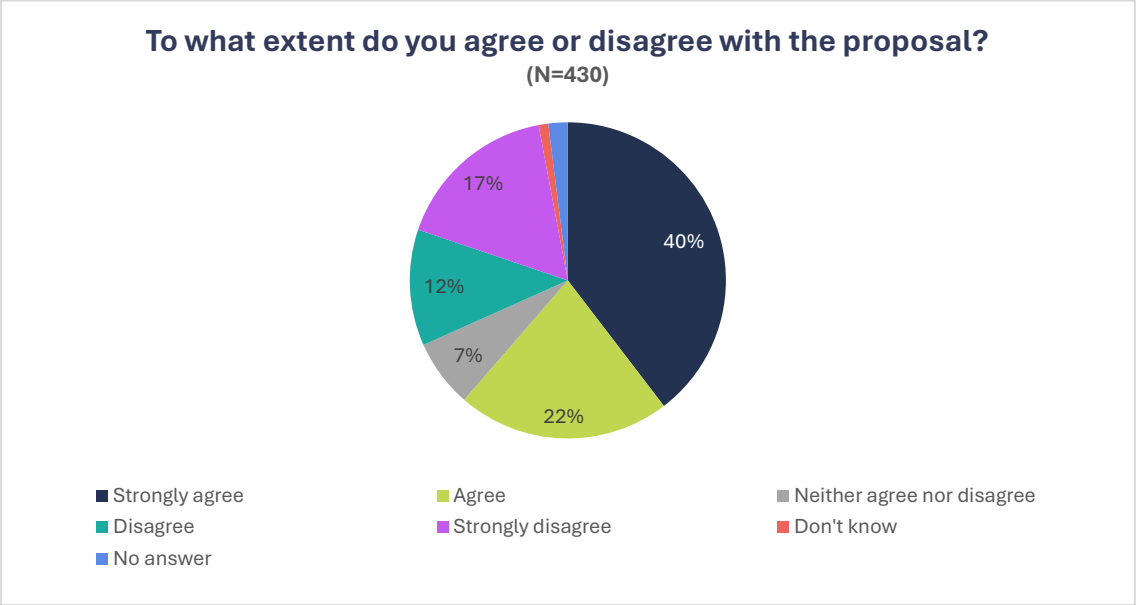

Chart 1: To what extent do you agree or disagree with the proposal?

While overall agreement with the proposal was higher than disagreement, levels of agreement were not consistent across all respondent groups. Analysis by respondent characteristics identified a number of statistically significant differences.

Healthcare and social care professionals

Healthcare and social care professionals were significantly more positive than non-professional respondents, although a majority of the latter (54%) also agreed with the proposed change. Overall, 72% of healthcare and social care professionals agreed with the proposal (50% strongly agree, 22% agree), while 21% disagreed (12% strongly disagree, 9% disagree).

Experience of transfer of care

Respondents whose close contact had experienced an emergency or unplanned transfer of care were significantly more likely to strongly agree with the proposal. Among this group, 69% strongly agreed compared with 39% of respondents with no personal or close contact experience of planned or unplanned transfer of care.

However, respondents who had personally experienced a transfer of care were more divided in their views. Among those who had experienced a planned move themselves, agreement and disagreement overall were evenly split (50% each)*. Among those who had experienced an emergency or unplanned move themselves, 46% agreed and 46% disagreed overall*.

*denotes a subgroup containing 20 or fewer respondents

Pregnancy and recent birth

Respondents who were currently pregnant or had recently given birth were significantly less likely to agree with the proposal than other respondents. Among respondents who were currently pregnant or had recently given birth, 37% agreed overall with the proposal and 56% disagreed overall. By comparison, 65% of respondents who were neither currently pregnant nor had recently given birth agreed overall with the proposal, while 25% disagreed overall.

Direct service experience of maternity or gynaecology services

Among respondents with direct service experience, those who were not healthcare or social care professionals were more likely to disagree with the proposal than those who were healthcare or social care professionals. Overall, 40% of non-professionals with direct service experience disagreed with the proposal, compared with 27% of healthcare and social care professionals with direct service experience. Among respondents who had used maternity services, 49% of non-professionals disagreed overall, compared with 29% of healthcare and social care professionals.

Reasons for respondents' views

Respondents were invited to explain the reasons for their level of agreement or disagreement with the proposal and/or outline any impacts they felt should be considered as part of the proposed change.

Responses reflected a range of perspectives on the proposal. The most commonly identified theme related to patient safety and specialist acute care, featuring in 49% of responses. This was followed by retaining services at Liverpool Women's Hospital (21%) and Royal Hospital capacity and suitability (18%). Other commonly identified themes included mother and baby care, and implementation and operational concerns (both 12%), alternative service models (10%), staffing concerns and resource allocation (9%), and cost and value for money (8%).

Clear differences were evident between respondents who agreed with and those who disagreed with the proposal. Responses from those who agreed with the proposal were strongly associated with themes relating to patient safety and specialist acute care. In contrast, respondents who disagreed with the proposal were more likely to express views relating to retaining services at Liverpool Women's Hospital and concerns about Royal Hospital capacity and suitability. Respondents who neither agreed nor disagreed with the proposal tended to express views relating to implementation and operational considerations.

Differences were also evident between respondent groups. Patient safety and specialist acute care were more prevalent among healthcare and social care professionals, while retaining services at Liverpool Women's Hospital and mother and baby care were more prevalent among maternity service users and respondents who were currently pregnant or had recently given birth.

Patient safety and specialist acute care

Patient safety and specialist acute care was the most common theme identified as an explanation of why respondents agreed or disagreed with the proposed change, featuring in 49% of responses.

The vast majority of responses within this theme came from respondents who agreed with the proposal. Patient safety and specialist acute care was identified in 74% of responses from respondents who agreed with the proposal, compared with 6% of responses from those who disagreed. The theme was also more prevalent among responses from healthcare and social care professionals (59%) than among non-professionals (40%). References to patient safety and specialist acute care were particularly common among respondents whose close contact had experienced an emergency or unplanned transfer of care (66%).

Many respondents focused on the availability of specialist expertise, equipment and support services. These respondents commented on the importance of providing care in an environment where specialist teams and facilities were immediately available.

> *"I think that where the need for additional support for delivery or surgery can be anticipated, it makes sense to place the patient in the safest environment where there are a range of specialist staff and equipment e.g. stoma nurse, dialysis equipment. The disadvantage is that it's not always possible to predict who may require additional support. However, if the facility was available a precautionary approach is then an option."*

> *"Agree in the sense that if they are complex surgeries/birth I would rather be in the best place possible to have a safe operation or birth and with the best people for them, the location isn't an issue for me."*

> *"Patient safety is the priority and having immediate access to other speciality care when necessary is paramount."*

> *"Complex and high risk care in the context of women's health should be delivered in a centre where all potentially necessary services are available to deliver the highest quality multidisciplinary care, which should be the highest priority. Not to do so compromises patient care, delays definitive treatment and introduces unnecessary risk."*

Respondents also referred to access to critical care services and the risks associated with emergency or unplanned transfer between hospital sites.

> *"Women should be cared for in the location that provides them with the quickest access to intensive care should they need it. If a woman's condition is already known to be high risk, it makes sense to plan in advance for delivery at the Royal rather than risking a transfer at an already critical time."*

“The proposal will be safer and have higher quality care if undertaken at the Royal site in a planned and systematic manner rather than the current procedure of a blue light transfer...”

“Safety must be first. I would want to know I was surrounded by specialist teams who could help me without an ambulance journey.”

"As an experienced midwife at Liverpool for 36 years I feel this is the right move. We see a lot of complex high risk cases and the risk of transferring women is too high especially during obstetric emergencies. Women and babies are put at risk."

A number of respondents described patient safety as the key factor in determining where complex care should be provided.

“The safety of women and babies must come first.”

“Safety of mothers and babies should come first! Being in a facility that can deal with complications is the most important thing.”

"If it saves lives of mums and babies it’s got to be a good thing."

"Having had a complex pregnancy, I would have wanted whatever was deemed appropriate and safest for both my son and I. If this meant delivering him in a hospital other than the Women’s Hospital, this would have been something I’d have done."

“If it is for the benefit of the baby and/or mother then absolutely the care should be moved to somewhere that can accommodate.”

“I agree with the proposal, the safe care of women during childbirth and gynaecology surgery is paramount and if the location at RLH is the safest place for this to happen, then it’s clearly the best option.”

Some respondents commented more broadly on the benefits of locating complex maternity and gynaecology care alongside acute hospital services.

"Seems like a no brainer to take care of the most complex and high risk cases at a site which will provide all services under one roof rather than be in an emergency situation which could potentially put the woman and her child in danger and at greater risk of harm and complications."

“Having worked at the Women’s, I don’t believe they have the infrastructure and interventions required to safely manage high risk patients. I believe this proposal will save lives.”

"I can see the benefits to having medically complex cases in close proximity to the general side of the hospital including intensive care."

“All gynaecology and obstetrics care should be at the Royal Liverpool Hospital where there is an intensive care [unit] and acute staff. Just because birth is low risk does not mean it’s going to go as planned. Having women’s health care down the road separate to everything else is so outdated and adds to the health inequalities in women’s health care, you wouldn’t make a hospital for males down the road and have them undergo surgery with no ITU.”

“Safe care should be the priority, not sentimental attachment to a site. Co-locating all maternity and gynaecology services at an acute adult site makes the most sense, but especially ‘high risk’ cases. The wider maternity provision must also be considered, it’s not simply the direct clinical care from obstetricians/midwives/support workers but all of the feed in aftercare services too, these should be offered equitably at the Royal also.”

A small number of respondents who referenced patient safety also highlighted limitations of the proposal, including the potential impact on mothers and babies and the fact that not all clinical risks can be predicted.

"I understand that it could be beneficial to have high risk procedures undertaken at a site with an adult ICU. However, I would imagine most of those 150 you mention would not require ICU care and LWH is well set-up to provide HDU care in these cases. There is also the issue of separation between mother and baby which should not happen wherever possible..."

"I think that the current situation is unsafe. It is hard to always predict which patients are going to need extra, specialised care such as ITU or input from other specialties. Thus, moving some patients will not get rid of the risk to those who continue to be cared for on the Women's Hospital site.”

Keeping all care at Liverpool Women's Hospital

Keeping all care at Liverpool Women's Hospital was the second most common theme identified in response to this question, featuring in 21% of responses.

This theme was strongly associated with disagreement with the proposal. It was identified in 54% of responses from respondents who disagreed with the proposal, compared with 7% of responses from those who agreed.

This theme was also more evident among respondents with direct experience of maternity services, being identified in 32% of responses from this group.

References to keeping all care at Liverpool Women's Hospital were particularly common among respondents who were currently pregnant or had recently given birth. It was identified in 40% of responses from currently pregnant respondents and respondents who had recently given birth, compared with 19% among respondents who were neither currently pregnant nor had recently given birth.

Many respondents referred to the importance of having a dedicated specialist women's hospital and highlighted the specialist nature of services currently provided at Liverpool Women's Hospital.

> *"I think it is important for women and mothers across Liverpool to use the specially designed Liverpool Women's Hospital that we have to treat us."*

> *"We need a dedicated women's hospital, the Royal is a general hospital."*

> *"I disagree in regard to the proposal of moving services. The Liverpool Women's hospital is a specialist hospital providing specialist care. So I would like the maternal services to remain in a specialist hospital."*

> *"Women should and must have a dedicated facility. The Women's delivers excellent services. Fund it properly and expand on the current site."*

Some respondents also referred to the environment provided by Liverpool Women's Hospital and its suitability for women, babies and families.

> *"...women choose the Women's Hospital as it is catered to women and would hopefully be a safe space. Transfer of care to another hospital degrades that security. It would be more impactful to upgrade services at the Women's to support these complex cases."*

> *"Having all services at the Women's hospital feels safer and all in one place. It also makes it easier for families to stay together."*

A further group of respondents suggested that investment should be solely directed towards Liverpool Women's Hospital to enable it to provide care for women with more complex needs.

> *"Instead of exporting these patients to [the] Royal, why can't provisions be provided to make [the] Women's be able to deal with such patients?"*

> *"Women's hospital should be resourced appropriately to cope with all cases."*

> *"Resource the Liverpool women's first to deal with these issues, not outsource to an already stretched Royal Hospital."*

> *"The care of mothers and babies is already being provided at the Liverpool Women's Hospital. Further investment is needed at that hospital where staff are already trained in dealing with high risk situations when they arise. Moving some women and babies from the Women's hospital will provide a two tier system."*

Some respondents linked their preference for retaining all services at Liverpool Women's Hospital, with concerns about moving some high risk care to the Royal Liverpool University Hospital.

> *"There isn't enough room at the Royal Liverpool Hospital for gynae/maternity operations/services. There should be more money invested in the Women's hospital to have all the services in one place. This is better for newborn babies & their mothers."*

> *"Women need a separate specialist hospital. If greater support / improvements of facilities are needed funding should be directed to Liverpool Women's for this. Other hospital A&E services are already too overwhelmed that levels of care would be diluted."*

> *"The Women's hospital is perfectly positioned to ensure the safety of mother and child away from the general population that use the Royal. This is nothing more than a cost cutting exercise that will see a worsening of the care to mother and child. Any attempt to close the Women's should be strongly opposed."*

Royal Liverpool Hospital capacity and suitability

Royal Liverpool Hospital capacity and suitability was identified in 18% of responses, making it one of the most commonly expressed themes.

The theme was considerably more prevalent among respondents who disagreed with the proposal, appearing in 39% of responses from respondents who disagreed with the proposal, compared with 6% of responses from those who agreed. It was also more

common among respondents with personal or close contact experience of transfer of care (28%) than among other respondents (16%).

Some respondents questioned whether the Royal Liverpool University Hospital was an appropriate environment for maternity and gynaecology services. Comments focused on the differences between a specialist women's hospital and a general acute hospital.

> *"Royal don't have the supplies for labour /birth like the Women's do."*

> *"I wouldn't want to give birth in a hospital that has sick, contagious patients in there and walk my baby out through that hospital."*

> *"High risk pregnant women shouldn't be forced to walk through more infectious hospitals, potentially see drunk people. I don't believe the Royal was built with pregnant women or babies in mind."*

A common concern raised by respondents related to capacity within the Royal Liverpool University Hospital. Respondents referred to bed availability, staffing levels and existing pressures on services.

> *"The Royal is already overstretched…lack of beds, lack of staff, horrendous parking!"*

> *"There is insufficient room in the Royal Hospital, beds have been massively reduced. Areas are poorly understaffed. Waiting times are anywhere from 16 to 24 hours. I cannot see how you propose to fit a designated area in the building for this plan."*

> *"Already insufficient beds at Royal Liverpool University Hospital. Corridor care in A&E frequently reported in local press. Where are they going to find beds for high risk maternity patients & 24hr obstetric & midwifery staff?"*

> *"There is no capacity for these at the Royal and moving them to the Royal will displace other activity already occurring there."*

> *"The "New" Royal is already too small and well over crowded with both patients and staff. Clinics are bursting and patients are having to wait in corridors, some really poorly."*

Some respondents questioned whether the facilities and infrastructure currently available at the Royal Liverpool University Hospital could accommodate the proposed change.

> *"There isn't any space at the Royal to accommodate these patients nor is there space at Aintree. I understand the logic for complex patients but the current Royal is not the place. These services need dedicated independent*

> *spaces. Facilities are over stretched already, support services are stretched and access is dreadful. Have you ever tried to get a lift to the 9th floor? Theatre space is full. What will these patients displace? Is corridor care for maternity services going to be common practise like it is for everyone else at [the] Royal and Aintree?"*

Mother and baby care

Mother and baby care was identified in 12% of responses.

The theme was more prevalent among respondents who disagreed with the proposal than among those who agreed with it, appearing in 19% of responses from respondents who disagreed with the proposal, compared with 9% of responses from respondents who agreed.

The theme was particularly evident among respondents who were currently pregnant or had recently given birth. It was identified in 25% of responses from respondents who were currently pregnant or who had recently given birth, compared with 11% of responses from respondents who were neither currently pregnant nor had recently given birth.

A common concern raised by respondents was the possibility that mothers and babies could receive care on different sites. Respondents commented on the implications of transfer arrangements and the importance of mothers and babies remaining together where possible.

> *"The risk is clear here, women being separated from their babies at or shortly after birth. The Royal is not equipped to provide maternity care and is unlikely to support newborn infants either, creating a potentially traumatic situation for parents and forcing birth partners to choose which site to be at..."*

> *"I think it is important to women and their families that if urgent care was required after giving birth, both the mother and baby are not in separate hospitals."*

> *"If women were sent to the Royal then that would indicate they would be away from their newborns - having complex care is psychologically challenging for the patient and this would be worsened by being in a different building than their child."*

> *"For these complex situations it does make sense, as long as both mum and baby can stay together and cared for together. This may become problematic if NICU is needed (if you're in hospital as a new mum, being on the same site as your baby is critical for your recovery and mental health). I say this as I have experienced NICU."*

Respondents also raised questions about how neonatal and specialist baby care would be provided under the proposed model, particularly where babies required neonatal intensive or special care.

> *"How are the babies going to be cared for? How are neonatal services going to be safe on a site away from the main unit? What provisions will there be for ensuring the same care is provided for neonates as would be provided in LWH. The baby must be cared for on the same site as the mothers so how will this work? I haven't read anything that puts the baby as a priority."*

> *"The Royal is better equipped to look after women who require a higher level of care. The disadvantage of this is that there is no neonatal care on the same site and if the baby needs neonatal care, they will be required to be transferred which poses a risk to them."*

> *"Transferring desperately ill women to access intensive care across the city is wrong. However, unless services for their babies (many will need intensive /special care) can be properly provided on [the] Royal site transferring care of such women wholesale would only create problem[s] for babies."*

> *"Safety of patients has to come first. But baby being with mother needs to be considered. If mother too unwell with baby, then baby needs to be at women's to get support."*

> *"I don't like the idea that if a woman has a baby at the Royal and is in critical care there, and her baby needs NICU they will be transferred back to the Women's. If you're going ahead with this, have NICU beds available at the Royal too so the mothers are not separated from their babies."*

Implementation and operational concerns

Implementation and operational concerns accounted for 12% of responses.

Implementation and operational concerns were expressed equally by respondents who agreed and disagreed with the proposal. The theme was mentioned by 10% of respondents who agreed and 11% of respondents who disagreed.

> *"Possible disconnected care due to communication and record keeping systems not linking up - having joint access to record keeping and notes would be essential. If this is not possible there needs to be clear protocols for information sharing... There is also the possibility of challenges in the mother and baby then being separated - clear communication and planning with families and the preparation conversations and consent would need to be planned prior to birth where possible."*

> *"Supportive of any service changes that demonstrably improve patient safety and clinical outcomes. However, it is important that any transfer of highly complex care is supported by a robust workforce plan, clear clinical pathways, maintenance of specialist expertise, and consideration of patient experience and access... For 150 patients there is a legitimate question about whether the benefits outweigh the cost and complexity of relocation."*

Alternative service models

Alternative service models were identified in 10% of responses. The theme was raised by respondents with a range of views on the proposal, including 9% of those who agreed overall and 10% of those who disagreed overall.

> *"If you are spending the money to set up specialist facilities at RLUH, and then needing specialist staff to come over from the Women's as required, why don't you just set it up at the Women's site? Also, why not open up the maternity unit at Aintree?"*

> *"I feel that staff work best in areas that they are familiar with, where they know where to find all of their necessary equipment. I feel for high risk births, women would want the expertise of the midwifery team which you don't get in a general hospital. I believe they would also want the NICU on their backs which again wouldn't be immediately available. For complex gynae surgery, involving multi organs, perhaps yes doing it on the site of the Royal where different specialties are available would be better. Otherwise, can a critical care team not just be on standby at Liverpool Women's for high risk births? It's all about cost saving, and by doing that you're taking away trust and confidence in your patients."*

> *"While an improvement over the current model, [it] still means there will be risks and possible dilution of staff and skills over the two sites. Need to move towards all of the Women's being on the Royal site."*

In addition to the alternative approaches outlined within this theme, respondents proposed a wider range of alternative options across multiple engagement questions. To support consideration of these alternatives as part of the decision-making process, they have been collated and are reported separately in Section 4.7.

Staffing concerns and resource allocation

Staffing concerns and resource allocation accounted for 9% of responses.

The theme was more prevalent among respondents who disagreed with the proposal (14%) than among respondents who agreed (5%).

> *"RLUH has limited beds as is. Who will staff this to ensure women are getting all the care they receive such [as] infant feeding who are in the Women's already."*

> *"At present the trust is struggling to accommodate the amount of patients that we have, where does the trust propose that these 150 women be cared for? Who are the specialist[s] that will be looking after these women?"*

> *"Totally agree that individuals undergoing complex surgeries/procedures should have immediate access to critical care should it be required. High risk cases are easily identified. I feel this for all individuals, not just the complex ones although starting with the complex patients is at least a start. Although I have read the booklet, my main concern would be the allocation of "specialists" across sites. How would there be specialists in both centres given the doctor shortage now. Having critical care available is vital, however the specialist doctors are vital for best care. My main consideration would be how this looks in reality - who can realistically be where and when."*

> *"I have no confidence that the Royal hospital would be staffed appropriately and with staff with the necessary competencies."*

> *"I agree that it will benefit those high risk patients. But I don't understand where the money will be found to provide extra staff/services when the service is already overstretched and short staffed."*

Cost and value for money

Cost and value for money featured in 8% of responses.

The theme was more prevalent among respondents who disagreed with the proposal than among those who agreed (14% compared with 5%).

> *"The leaflet did not give costed options, neither a cost / benefit analysis so it is not clear to me that this would be money well spent."*

> *"The cost of doing this is too high in comparison to funding Liverpool women's hospital properly."*

"What a grotesque waste of NHS money to separate maternity services from acute trusts only to pay millions more to move them back because it isn't working for all patients. In doing this, the services available at the Women's site would be extremely stretched to the point of unsafe for other "low risk" pregnancies. The only truly safe way to operate this model is to have the Women's hospital on the same site as the acute services."

"I feel that the expense of implementing this proposal seems disproportionate for the 1% it is focussing on. I feel that there must be a more cost beneficial solution."

"Option 2 will cost £2m to create new spaces at both the Women's and the Royal, and £5.5m on extra staff including for the complex births & gynae at the Royal but your booklet p.19 it says funds for this will come from existing budgets. How is this achievable when the Ockendon report clearly recommends for funding to increase if quality care standards are to be met?"

Experiences of care

The theme of experiences of care accounted for 7% of responses.

The theme was more prevalent among respondents with personal or close contact experience of transfer of care than among respondents with no experience of transfer of care (14% compared with 5%). It was also more common among respondents reporting a disability (12%) than among respondents reporting no disability (5%).

"For extreme high risk cases I agree. However as a high risk mother myself, I had both of my children at the Women's and the support and specialist services where second to none. I'm so glad I could have children and also have them in the Women's. I only agree with the proposal as in birth transfers can be risky."

"I had cardiomyopathy during my son's birth, the Women's hospital staff were not equipped to deal with it and I ended up in Wythenshawe almost requiring [a] heart transplant. Could not even perform an echo..."

"My daughter had horrendous birth experiences at the Women's hospital and her last delivery resulted in her having to be transferred to the Royal. The Women's hospital also sent her to the Royal before she was finally admitted, for a scan (by taxi, as no ambulance available). When the Royal admitted her, she wasn't able to take her baby with her, and she was breastfeeding him."

Other themes

Several less frequently occurring themes were also identified in responses.

Future of Liverpool Women's Hospital

The future of Liverpool Women's Hospital was identified in 5% of responses. This theme was more common among respondents who disagreed with the proposal, appearing in 14% of responses from respondents who disagreed with the proposal, compared with 2% of responses from respondents who agreed.

> *"The Women's hospital is a fantastic asset unique to our city and undermining and weakening its delivery of services is a short-sighted move. This proposal seems to be the start of a slippery slope to cut services at the Women's hospital and ultimately erode this specialist site."*

> *"Invest in Liverpool Women's Hospital so those 150 women can be cared for in their hospital, safely. Don't take care elsewhere to further justify closing our hospital!"*

Access, travel and equality

Access, travel and equality was also identified in 5% of responses. This theme was more common among respondents who disagreed with the proposal, appearing in 10% of responses from respondents who disagreed with the proposal, compared with 2% of responses from respondents who agreed.

> *"Royal Liverpool has nowhere for women in labour to be safely dropped off, nor anywhere for a woman to safely leave with a newborn. The parking is non-existent."*

> *"Liverpool Women's is easier to access and park without having to go into the city centre. It also gives more reassurance as a hospital dedicated to women's care."*

> *"The Royal is more difficult to get to and parking worse."*

Transparency and engagement process concerns

Transparency and engagement process concerns was identified in 2% of responses. Although relatively uncommon overall, the theme was more prevalent among respondents who strongly disagreed with the proposal, appearing in 8% of responses from this group.

> *"This "engagement" is a step towards moving all, or at least the bulk of services currently available at the Crown St. site to the New Royal. The long running campaign Save Liverpool Women's Hospital has been aware of this since the campaign started over a decade ago. Whilst Option 2 is the only*

one currently presented, the real intentions of the ICB are clear in Option 6, to move all inpatient gynae, maternity and neonatal to the New Royal."

"You are not a truthful organisation, this is not a case of improving services, this is a case of cutting costs."

Integration with national maternity reviews and recommendations

Integration with national maternity reviews and recommendations was identified in 1% of responses, making it the least common theme.

"I am against transferring complex cases in light of the Amos report findings which highlight the systematic failures which exist in primarily general hospitals, such as the Royal hospital."

Other comments

Other comments accounted for 5% of responses. These responses were reviewed as part of the analysis but did not form distinct themes relevant to the proposed changes. They typically related to individual issues, contained limited substantive comment, or raised points that were not directly relevant to the proposals, and have therefore not been reported separately.

4.5 Equality considerations raised by respondents

Respondents were asked whether they thought the proposed changes could have positive or negative impacts on people with protected characteristics under the Equality Act 2010, or on other groups, and whether there were any actions the NHS should take to reduce potential negative impacts or increase positive impacts.

While nearly half of respondents did not provide an answer to this question (47%), the most common themes that emerged related to protected characteristics and inclusion (16%), quality, staffing and service delivery (12%), women's health and specialist care (8%), access, transport and financial barriers (7%), and patient choice and dignity (6%). Around a tenth of respondents to the survey (9%) said they had no concerns about equality issues.

There were some differences by level of agreement with the proposal and respondent characteristics. The 'no equality concerns' theme was more common among respondents who agreed with the proposal, while 'women's health and specialist care' was more common among respondents who disagreed with it. 'Patient choice and dignity' was particularly evident among respondents who had recently given birth or who were currently pregnant.

More detail of each of the response themes is provided below.

Protected characteristics and inclusion

The most common theme identified in response to this question related to protected characteristics and inclusion, featuring in 16% of responses.

This theme was evident among a wide range of respondents and was not strongly associated with either agreement or disagreement with the proposed changes. However, it was more prevalent among respondents reporting a disability (24%) than among those reporting no disability (15%).

> *"It is important that the patients who are accessing this service are not automatically seen and screened as "women". This is due to the fact that a portion of the patients accessing the service are transgender and do not identify as women. In keeping with the Equality Act 2010 and the Gender Recognition Act 2004, these services should be catered toward "people who menstruate", "birthing parents" and "patients" instead of "women", "ladies", or "mothers". If outdated language is used, patient care is negatively affected, and a plethora of service users will be left feeling unsafe, unseen, and disrespected."*

> *"My experience as a lesbian was very good. Staff were very understanding and allowed my wife to stay in the hospital once I had given birth. All staff were very aware of LGBTQ and used appropriate language and were very supportive."*

> *"There is national evidence that indicates women who are black have poorer maternity and health care. This must be addressed."*

Quality, staffing and service delivery

Quality, staffing and service delivery featured in 12% of responses.

The theme was particularly evident among respondents who strongly disagreed with the proposal, where it appeared in 20% of responses.

> *"Pregnant and postnatal women and women in general already suffer discrimination and struggle to have their voices heard. Adding complex cases to an already overstretched service at the Royal, where staff are not specialist in delivering care to women, could result in increased discrimination."*

Women's health and specialist care

Women's health and specialist care featured in 8% of responses.

This theme was more prevalent among respondents who disagreed with the proposal, appearing in 17% of responses from respondents who disagreed with the proposal

compared with 6% of responses from those who agreed. The theme was particularly evident among respondents who strongly disagreed (20%).

> *"What could better serve the needs of women but a Women's hospital. SO much opportunity to get things right for this population..."*

> *"Women are consistently not listened to and symptoms are easily dismissed which is why the Women's is such an important hospital focusing on women's care. A disadvantage would be a woman needing specific care and being sent to a general hospital where there may not be the knowledge to take symptoms seriously."*

Access, transport and financial barriers

Access, transport and financial barriers featured in 7% of responses.

This theme appeared among respondents with differing views on the proposal, with relatively little variation between those who agreed with and disagreed with the proposal.

> *"Are the car parking costs the same at the two sites? LUHFT had some of the costliest car parking in the country a few years ago, which could disadvantage some patients and their families if they had to park somewhere more expensive than they are used to."*

> *"In the event of moving all women's health services to the Royal, have you considered the impact on BAME women, as a great number live in close proximity to Crown Street. What of the environmental impacts of moving services to one of the most traffic dense areas of the city? Have the effects of charging migrant women for health care been considered or the antenatal care of asylum seekers being moved around the country?"*

> *"Moving services to the Royal Liverpool Hospital will make it more difficult for disabled people to access services as it is a long way from car parks (and on a hill) and there are limited dropping off points. The Women's Hospital was deliberately built in an area to encourage greater accessibility for BME women, so moving patients to RLUH would be a backward step."*

Patient choice and dignity

Patient choice and dignity featured in 6% of responses.

This theme was particularly evident among respondents who had either recently given birth or were currently pregnant (17%), compared with respondents who were neither currently pregnant nor had recently given birth (4%).

"Disability - you're preventing high risk pregnant women from having their choice of place of birth due to a health problem they have."

"Ensuring that trans people who are giving birth are looked after in a way that feels dignified and protects their right to privacy would be better done at a hospital where being a 'woman' is the proposed norm. If a trans man was giving birth and put into a maternity bay, this would cause tension and undue distress."

Need for investment in Liverpool Women's Hospital, not cuts

This theme featured in 5% of responses and was more strongly associated with respondents who disagreed with the proposal. It appeared in 15% of responses from respondents who disagreed with the proposal, compared with 1% of responses from those who agreed.

"This hospital needs investment and not cost cutting. So many of our services have been affected negatively by trying to amalgamate services. Larger is not better."

"Women's services have been depleted in every way over the years. Specialised care for pregnancy, postnatal care and gynaecological care should all be based in a women's only hospital. We should be adding to that care not taking away from it."

No equality concerns

No equality concerns were identified in 9% of responses.

This theme was more prevalent among respondents who agreed with the proposal, appearing in 12% of responses from respondents who agreed with the proposal compared with 2% of responses from those who disagreed. It was particularly common among respondents who strongly agreed with the proposal (15%).

"This has to be about providing optimal medical care; I cannot envisage any negative impacts."

"I believe the NHS should and does treat the patients in relation to what their health needs require, with individuals receiving the best, most appropriate care, regardless of any equality distinctions."

"I think maternity services should be as neutral as possible with the focus on a healthy mother and child - making everyone aware that while equality is given consideration to make people feel comfortable - it's the same service for each woman."

Other themes

Several less frequently occurring themes were also identified within responses. 'Need for clear communication and pathways', and 'continuity of care and family support' each featured in 4% of responses. A small number of respondents also raised concerns about the engagement process or wider strategic plans for services (1%). Mental health and wellbeing was identified in a very small number of responses. A further 4% of responses were categorised as other comments. These responses were reviewed as part of the analysis but did not form distinct themes relevant to the proposed changes. They typically related to individual issues, contained limited substantive comment, or raised points that were not directly relevant to the proposals, and have therefore not been reported separately.

4.6 Additional comments from respondents

Respondents were also given the opportunity to provide any further comments on the proposal, including alternative solutions to the challenges identified by NHS Cheshire and Merseyside. A substantive comment was provided by 47% of respondents, while no answer was recorded for 53%. The percentages reported below are based on all respondents to the engagement.

The themes identified were varied, reflecting the broad nature of the question. The most common theme was retaining and investing in Liverpool Women's Hospital (13% of all respondents), followed by safety and access to specialist care (11%), workforce, staffing and specialist expertise (9%), concerns about the Royal's facilities, environment and patient experience (7%), and trust, transparency and confidence in decision-making (6%).

Retain and invest in Liverpool Women's Hospital

The most common theme identified in response to this question was retaining and investing in Liverpool Women's Hospital, featuring in 13% of responses. This was strongly associated with disagreement with the proposal, appearing in 27% of responses from respondents who disagreed with the proposal, compared with 8% of responses from those who agreed. Within this theme, respondents reiterated the importance of Liverpool Women's Hospital and the need for continued investment in its services.

> *"More funding to Liverpool Women's hospital. The health and mental health needs of women and specifically pregnant women is already in crisis and has been for some time. Merging these services with other hospitals is a step back not a step forward. Fund Liverpool Women's properly."*

> *"Investment in LWH [Liverpool Women's Hospital]. Keep the facilities and complex care at LWH rather than moving to the Royal."*

"I think the Women's hospital should be adequately resourced instead of outsourcing to the Royal."

Safety and access to specialist care

Safety and access to specialist care was identified in 11% of responses. This theme was more prevalent among respondents who agreed with the proposal, appearing in 16% of responses from this group, compared with 3% of responses from those who disagreed. The theme was also significantly more prevalent among healthcare and social care professionals (14%) than among non-professionals (7%). Within this theme, respondents focused on the importance of clinical safety and access to specialist care.

"I think that where care happens (i.e. which hospital) is much less important than having the right specialists on hand. Most people just want to be in the best place for the best care."

"I think those against the move of high risk cases to RLUH [Royal Liverpool University Hospital] are not understanding the bigger picture of optimising patient care, safety and outcomes. For example, morbidity and unfortunately, mortality [in] obstetrics is on the rise and this move would hopefully improve outcomes and help these women/service users that require services that are not available on site at LWH [Liverpool Women's Hospital]."

"I love the LWH [Liverpool Women's Hospital] building. Ultimately however I think it would be in the best interests of patients to have obstetric and complex gynaecology care sited closer to ITU [Intensive Therapy Unit], labs and other specialist care such as gastrointestinal surgery."

Workforce, staffing and specialist expertise

Workforce, staffing and specialist expertise featured in 9% of responses. This theme was more prevalent among healthcare and social care professionals (13%) than among non-professionals (5%). Within this theme, respondents commented on workforce capacity, staffing and the availability of specialist expertise.

"In my experience, maternity services are not what they could be… it is vital to consider the basics of care - i.e. will the right number of staff and the right level of training be given/available to ensure safe treatment?"

"Are you sure you will get staff to work in the proposed 6-bedded enhanced unit? It doesn't look like a very attractive option for critical care trained nurses, nor for midwives, nor for medical staff."

"There is … a national shortage of midwives so how many midwives would be needed to work at the Royal site? Will this be a new job post or will staff

move from Liverpool Women's to the Royal? Which will further impact the staff issues at LWH [Liverpool Women's Hospital]."

Concerns about the Royal Liverpool Hospital's facilities, environment and patient experience

Concerns about the Royal Liverpool Hospital's facilities, environment and patient experience were identified in 7% of responses. This theme was more prevalent among respondents who disagreed with the proposal, appearing in 13% of responses from respondents who disagreed with the proposal, compared with 5% of responses from those who agreed. Within this theme, respondents focused on the suitability of the Royal Hospital site and the potential implications for patient experience.

"Please consider the privacy of ladies and consider the impact of putting this service in the Royal which doesn't seem to have the room as it is. I was in A&E last weekend and witnessed many patients in corridors on trolleys especially women."

"Not enough room at the already bloated RLUH, no adequate parking facilities for families that don't involve crossing main roads with small children or astronomical costs in Q park."

"I feel it's important to consider how new mothers would feel walking a new baby out and around of a main Hospital full of a range of viruses."

Trust, transparency and confidence in decision-making

Trust, transparency and confidence in decision-making featured in 6% of responses. This theme was more prevalent among respondents who disagreed with the proposal, appearing in 11% of responses from respondents who disagreed with the proposal, compared with 4% of responses from those who agreed. Within this theme, respondents commented on confidence in the decision-making process and the way options had been presented.

"The NHS should be transparent and include the patient within their decision making, so that the patient feels included and understands the reasons behind the move to another care setting. Just be honest."

"Unfortunately, it is likely this questionnaire is a tick box and not something that will be actually considered as decisions about the care of the population are typically made by people who have no direct involvement in delivering that care."

"Invest in the Women's. Listen to the public who want services to stay there!"

"If you want people to trust the decision, you need to provide a breakdown of how it will work in practice including pricing, equipment and staff increases."

"Why don't you just come clean and announce all care (excluding a few clinics) at LWH [Liverpool Women's Hospital] will be moving to the Royal. Stop all this wasting of time and be honest."

Other themes

Several smaller themes were also identified. These included relocating the entire Women's Hospital to the Royal site (5%), continuity of maternity, neonatal and family-centred care (5%), funding and resource allocation concerns (5%), transport, parking and accessibility (4%), alternative service configuration proposals (4%), infrastructure, facilities and operational readiness (3%), need for improved general maternity and gynaecology services (3%), concerns about equalities and discrimination (2%), and the importance of patient choice and informed consent (2%).

To support consideration as part of the decision-making process, alternative service configuration approaches raised across the engagement have been collated and are reported separately in Section 4.7.

4.7 Alternative approaches suggested by respondents

Respondents proposed a range of alternative approaches to addressing the challenges described by NHS Cheshire and Merseyside. These suggestions were raised across multiple questionnaire questions, including responses relating to the proposal itself, equality considerations, experiences of transfer of care, and additional comments. As these proposals were raised across several parts of the engagement, they have been collated and reported separately.

The alternatives included further investment in Liverpool Women's Hospital, development of additional specialist facilities at Liverpool Women's Hospital, relocation of all women's services to a single site, alternative configurations of maternity and gynaecology services, the use of alternative hospital locations, and improvements to transfer arrangements between existing sites.

Several of these suggestions are also reflected elsewhere in the report, particularly within themes relating to keeping services at Liverpool Women's Hospital, Royal Liverpool Hospital capacity and suitability, staffing and resource allocation, and continuity of maternity and neonatal care.

While these comments were suggested as alternative solutions, some respondents proposed measures that overlap with elements already included within the proposed package of improvements, such as additional investment in staffing, facilities and transfer arrangements.

Investment in Liverpool Women's Hospital

The need for greater investment in Liverpool Women's Hospital was identified by a number of respondents as an alternative to the proposal. Respondents suggested that additional funding should be directed towards expanding services, facilities and staffing at the existing hospital to enable a wider range of complex care to be provided on site.

> *"Why can the Women's not expand their own medical staff and provide additional care on their own premises? Time and time again proposals have been blocked by the council and funding has not been provided to give the Women's the ability to expand. Women's care should be taken seriously and not just women giving birth, all areas the Women's [hospital] covers is important and saves lives. They deserve the ability to expand their own premises and staff."*

> *"Why isn't a specialist unit built at Liverpool women's? Surely another floor or change of use, if [there are] areas of the building that are underutilised."*

> *"The Women's is equipped to deal with a lot of difficulties with pregnancy etc it would be more beneficial to staff and fund the hospital."*

> *"Invest money into the Women's hospital. Currently if there is a need for emergency care mother and baby are split up, mother would have to attend another hospital without baby for treatment. If you invest money to improve the service at the Women's there would be no need to take a woman's newborn child away from her. I have experienced this personally at the Liverpool Women's Hospital and the Royal Hospital and feel very passionately as it was a very traumatic experience for me."*

Developing specialist and critical care facilities at Liverpool Women's Hospital

A related suggestion was to increase the availability of specialist facilities currently accessed through transfer arrangements. Respondents suggested that critical care, specialist diagnostics and other acute services should be developed at Liverpool Women's Hospital.

> *"Can an ITU not be funded to keep all services at LWH? Would the ITU beds at the Royal be staffed with midwives or ITU nurses?"*

> *"I like the proposal of a high dependency unit at LWH and the provision of a dedicated team. Transfers will be early to minimise emergency situations and the women will be central to all decisions made."*

> *"Can a critical care team not just be on standby at Liverpool Women's for high-risk births?"*

Relocating all women's services to a single site

Some respondents considered the proposed changes to be only a partial solution and suggested that all maternity, neonatal and gynaecology services should ultimately be provided alongside acute hospital services on one site.

> *"A purpose built LWH, on the site of the old RLUH makes the most sense, with a sky bridge that connects to the new RLUH as Clatterbridge/CCSB do. Therefore, services are co-located and the old LWH could then be refurbished ready to be used as a second non-acute hospital like Broadgreen is, hopefully allowing to reduce patient blocking acute beds who are waiting for sub-acute care."*

> *"Develop the empty site where the old Royal Liverpool University Hospital used to be."*

> *"Eventually the ultimate plan should be to co-locate the Women's with the Royal Liverpool with capital investment."*

> *"Current situation is still dangerous with lack of medical support at the Women's, need to keep moving forward with the Women's being relocated to the Royal site in a new building."*

> *"Consider moving all cases to RLH and keeping the current site just as an outpatients location."*

Alternative configurations of maternity, neonatal and gynaecology services

Some respondents proposed alternative service configurations rather than agreeing or disagreeing with the proposal as presented.

Suggestions included retaining maternity and neonatal services together while moving some gynaecology services, increasing patient choice regarding where care is delivered, and providing additional neonatal facilities at the Royal site.

> *"Separating maternity and gynaecology services would be preferable; i.e. being placed on a maternity ward following a miscarriage is not acceptable, nor is having to share waiting rooms with expectant mothers when you are undergoing tests for infertility/gynae issues."*

> *"I would like all mums to continue to have their babies at RLUH site. I agree that higher risk Gynae surgery should take place on RLUH site."*

> *"If I were high risk or a complex case, I'd want to be near NICU, ICU, and paediatric / gynae / obstetric specialists. I don't know where the best place to have access to all of these is."*

Alternative locations

A smaller number of respondents suggested that other hospital locations should be considered.

Suggestions included expanding services at Aintree, using facilities at Whiston, or developing specialist provision across multiple locations.

> *"I feel this is a good idea, even to add that when pregnant women are in car accidents they attend A&E it would be better if there were specialist on site to help with the pregnancy at this time. Do I think it should be at the Royal, no, Aintree would be a better location."*

> *"I think maternity and gynaecology services should be moved back to Aintree Hospital. If you live in the north of the city or Knowsley it is a nightmare to get to the Women's and the Royal is a good distance away."*

Improving transfer arrangements

Some respondents suggested that the focus should be on improving transfer arrangements between hospitals rather than changing where care takes place.

These comments focused on reducing delays, improving communication, strengthening information sharing and making transfer processes more seamless for patients and families.

> *"Having worked within theatres at the Royal and receiving patient transfers from the Women's care needs to be better planned."*

> *"Discussions prior to birth of potential complications, threshold for caesarean and clear contingency plan. These discussions often take place during and it's lessons learned - preventative care."*

5 Feedback from interviews with women with lived experience of complex care

During the engagement, four one-to-one interviews were undertaken with individuals who had experience of complex or high-risk maternity and gynaecology care, including situations where care had been transferred between hospitals due to complications or the need for specialist support. Family members and carers with relevant lived experience were also eligible to participate.

Participants were identified and invited to take part because they had direct experience of the types of care pathways most relevant to the proposals being considered. Interviews were conducted online by NHS Cheshire and Merseyside staff using a structured discussion guide and explored experiences of care, communication, transfer between hospitals, access to specialist support, the impact on individuals and families, and opportunities for improvement.

Interviews were carried out in a confidential setting and participants were encouraged to share their experiences openly and in their own words. Findings have been reported anonymously and analysed thematically to identify common experiences, concerns and suggestions for improvement.

5.1 Analysis of interview findings

Analysis of the interviews identified several recurring themes across participants' experiences. Although each care journey was different, women consistently reflected on uncertainty while receiving complex care, the emotional and practical impact of transfer between hospitals, access to specialist expertise, separation from babies and family members, and the importance of communication, compassion and aftercare.

The findings presented below draw together these shared experiences while recognising the individual circumstances of each participant.

Experiences of complex care

The interviews highlighted participants' experiences of complex care. Their accounts included high-risk pregnancies, serious complications following childbirth, fertility treatment, emergency interventions and lengthy periods of treatment and recovery. Participants described periods of uncertainty, multiple investigations and the need to navigate decisions about their care while managing significant health concerns.

One participant described the point at which concerns were identified during her pregnancy:

> *"At 16 weeks, everything changed. During a scan, there was an obvious difference in the babies' weights – around 30%. Suddenly, I found myself surrounded by doctors, scans and uncertainty.*

> *One doctor gently explained that, if things became worse, the only way to save one baby might be to terminate the smaller twin… Hearing those words was devastating."*

Another participant described becoming unwell following treatment and not understanding the cause of her symptoms:

> *"I just knew something didn't feel right. That feeling continued and I kept saying to my partner, '(Partner) I think I'm going to die.' I couldn't explain why, but I felt desperately ill."*

One participant reflected on her recovery after significant complications during childbirth:

> *"This whole period was much worse than it needed to be because of the staff's expectation that I should be following a 'normal' recovery."*

Transfer and access to specialist services

All participants described care that involved, or could potentially have involved, access to specialist services beyond those available at the hospital where they were initially receiving treatment. Discussions focused on the availability of specialist expertise, transfer between hospitals and the co-ordination of care across services.

One participant described being transferred to another hospital when her condition deteriorated:

> *"My kidneys needed urgent treatment and my antibiotics also needed to be changed. I have almost no memory of that transfer because I was so critically ill. At the Royal, specialists were able to review my treatment and adjust the antibiotics appropriately."*

Another participant reflected on the importance of timely access to specialist support:

> *"When women need specialist care, they should be able to access it immediately – not hours or days later."*

A different participant felt that improving transfer arrangements should be a priority:

> *"If I could change the pathway to one that made it easier for patients to be transferred, then I would do that in an instant."*

Communication and continuity of care

Participants discussed the importance of communication throughout their care journeys. This included receiving information about treatment, understanding decisions about care, communication between different organisations, opportunities to ask questions about what had happened to them, and feeling listened to, supported and

reassured during periods of uncertainty and recovery. Experiences were mixed, with participants describing both positive and negative examples.

One participant, who received IVF treatment and specialist twin pregnancy care at Liverpool Women's Hospital, described feeling well supported by the staff involved in her care:

> *"Many of the staff members who cared for me had experienced multiple pregnancies themselves, and that personal understanding made a real difference. I felt listened to, understood and supported."*

Another participant described the challenges of navigating care across multiple organisations:

> *"The Women's Hospital, Arrowe Park, the Royal Liverpool Hospital and Manchester all held different parts of my story, but those pieces were never brought together. I became responsible for explaining my own medical history over and over again, despite often not fully understanding everything that had happened myself."*

Participants also reflected on the importance of compassion, reassurance and emotional support. One participant reflected on the reassurance she received after transfer to a different hospital:

> *"Then the doctor said, but don't worry, we will make you better. And that was the first time somebody had said anything that was in any way, shape or form, like... [to] reassure me."*

Impact on individuals and families

Participants described the impact that complex care had on themselves and their families. Alongside the physical consequences of treatment and illness, interviewees reflected on the practical and emotional implications of separation from babies, partners and support networks, particularly when transfer between hospitals was required.

One participant described concerns about being separated from her babies:

> *"The thought of being separated from my babies for an unknown amount of time was unimaginable and utterly heartbreaking."*

The same participant also reflected on the importance of being able to see her babies after birth:

> *"All I wanted was to see my babies. But first, I was told I had to prove I could walk and pass urine before I could leave recovery. Those three hours felt endless."*

A different participant described having to decide whether her partner should stay with their baby or accompany her during an emergency transfer:

> *"As they were getting me ready for the transfer they said to me, do you want [partner] to come with you or [partner] to stay with [baby]? And I'm like, well, I'm not leaving my baby with you. No, [partner] is not coming with me. I'll go on my own. You need to stay with [baby].*
>
> *"That's probably one of the things I struggled with the most at the time was the fact that I had to make a decision to leave my baby."*

Another participant reflected on the experience from her husband's perspective:

> *"While I was in theatre, he was sat in what he describes as a cupboard, alone with a brand new baby, no way to feed him and with no knowledge about what was happening to me, no one gave him any updates, and he didn't know where to go."*

Participants also described longer-term impacts beyond the immediate episode of care. One participant reflected on the cumulative effect of repeated treatment and fertility-related complications:

> *"My whole body had been through so much. There was the failed IVF, the repeated episodes of sepsis, multiple major operations and ultimately the grief of knowing I wouldn't be able to carry a child."*

Follow-up care and service improvement

Participants reflected on the support they received following treatment and identified opportunities to improve care. Particular emphasis was placed on follow-up discussions, understanding what had happened during their treatment, psychological support and improving coordination between services.

One participant described how a clinical debrief would have helped her understand her experience:

> *"After the birth, the operation…I didn't have any debrief with any doctor. I really feel like this would have helped me to come to terms with the birth and perhaps I could have understood why some of the decisions were taken."*

Another participant described the support she felt should routinely be available following significant treatment:

> *"After each episode of treatment, I would ensure there was a proper follow-up conversation where someone sat down and explained what had happened, answered questions and helped patients process everything they had been through. I also believe psychological support should be routinely offered."*

Participants also reflected on the value of being able to share their experiences as part of the engagement process. One interviewee commented:

> *"Being given the opportunity to tell my story and to have someone genuinely listen without interruption or judgement, has been incredibly healing."*

6 Feedback from other sources

This chapter summarises feedback received through a petition, correspondence, email, and social media channels during the engagement period. These routes provided an additional opportunity for stakeholders and members of the public to share their views, ask questions and seek clarification alongside the formal questionnaire, interviews and engagement events.

6.1 Petition presented to the ICB Board

A petition entitled 'Save Liverpool Women's Hospital' was presented to the NHS Cheshire and Merseyside Integrated Care Board on 28 May 2026.

A petition entitled 'Save Liverpool Women's Hospital' was set up on the 38 Degrees online platform eleven years ago. At the time of writing, the 38 Degrees petition has 51,203 signatures, however those involved with the Save Liverpool Women's campaign have reported that the figure has now reached 90,000, when paper-based petition signatures are included.

This will be taken into account, along with all other feedback arising.

The petition statement is below:

> *"Save Liverpool Women's Hospital*
>
> *"Save the Liverpool Women's Hospital. No closure. No privatisation. No cuts. No merger. Reorganise the funding structures not the hospital. Our babies and mothers our sick women deserve the very best.*
>
> *"Why is this important?*
>
> *"All the maternity and women's health provision of Liverpool was pulled into this one site. It's a much loved hospital. It provides crucial specialised care and the daily joy of new babies. #one born. The driving force for closure is a clumsy funding structure not the needs of women and babies. The alternative of wards in the new Royal is not an equivalent.*
>
> *"This is a modern hospital on a good site. Our taxes built it for our babies and for our women."*

6.2 Feedback from correspondence

NHS Cheshire and Merseyside received one questionnaire response by post during the engagement period.

The questionnaire was entered into the online engagement system and analysed alongside all other questionnaire responses. As a result, the feedback provided through

the postal questionnaire has been incorporated into the questionnaire findings presented in Section 4.

6.3 Feedback from emails

NHS Cheshire and Merseyside received two emails through the dedicated engagement inbox during the engagement period.

Both correspondents objected to the proposed changes. The issues raised through email reflected themes that also emerged through questionnaire responses, including concerns about capacity at the Royal Liverpool University Hospital, the future of Liverpool Women's Hospital, the potential separation of mothers and babies, and views that investment should instead be directed towards strengthening services at the existing Liverpool Women's Hospital site.

One respondent expressed concerns about capacity within the Royal Liverpool University Hospital, stating:

> *"The suggestion that the Royal Liverpool Hospital can absorb complex gynaecology and maternity cases ignores the severe bed shortage crisis unfolding on that site."*

The other respondent highlighted concerns about the long-term future of Liverpool Women's Hospital, commenting:

> *"The loss of the Women's Hospital would be the loss of a really valuable and specialist institution."*

The views expressed through email were consistent with themes raised elsewhere during the engagement and have been considered alongside all other feedback received.

6.4 Feedback from social media

Information about the engagement was promoted through social media channels throughout the engagement period. A total of 26 posts were published across Facebook, Instagram, X and LinkedIn, generating 9,566 impressions, 381 engagements and 24 click-throughs to the engagement website.

Although social media was used to promote awareness of the engagement and opportunities to participate, no comments or direct feedback on the proposals were received through the programme's social media posts during the engagement period.

7 Next steps

This report provides an independent summary of the feedback received during the engagement period. It does not make recommendations regarding the proposal. It brings together views shared through the questionnaire, interviews, correspondence and other engagement activities undertaken between 2 June and 14 July 2026.

NHS Cheshire and Merseyside will now consider the findings presented in this report alongside other evidence, including clinical, operational, financial and equality impact assessments. The feedback received through the engagement process will form one part of the information used to inform decision-making regarding the proposed changes to complex maternity and gynaecology services in Liverpool.

Following consideration of all available evidence, NHS Cheshire and Merseyside will determine whether, and how, it wishes to proceed with the proposed changes. Any subsequent decisions will be communicated through the programme's established communication channels.

Appendices

Appendix A: Demographic information

Appendix B: Engagement questionnaire

Appendix A: Demographic information

Demographic information from questionnaire respondents

Information collected from the questionnaire has been collated to provide a detailed overview of respondents' demographics.

Where people live

Just over half of respondents – 52% – lived in Liverpool, while 16% lived in Sefton, 10% in Knowsley, and 7% in Wirral. Smaller proportions lived in Cheshire West, St Helens, Halton, Cheshire East, and Warrington (each with 3% or less) (see Chart 2).

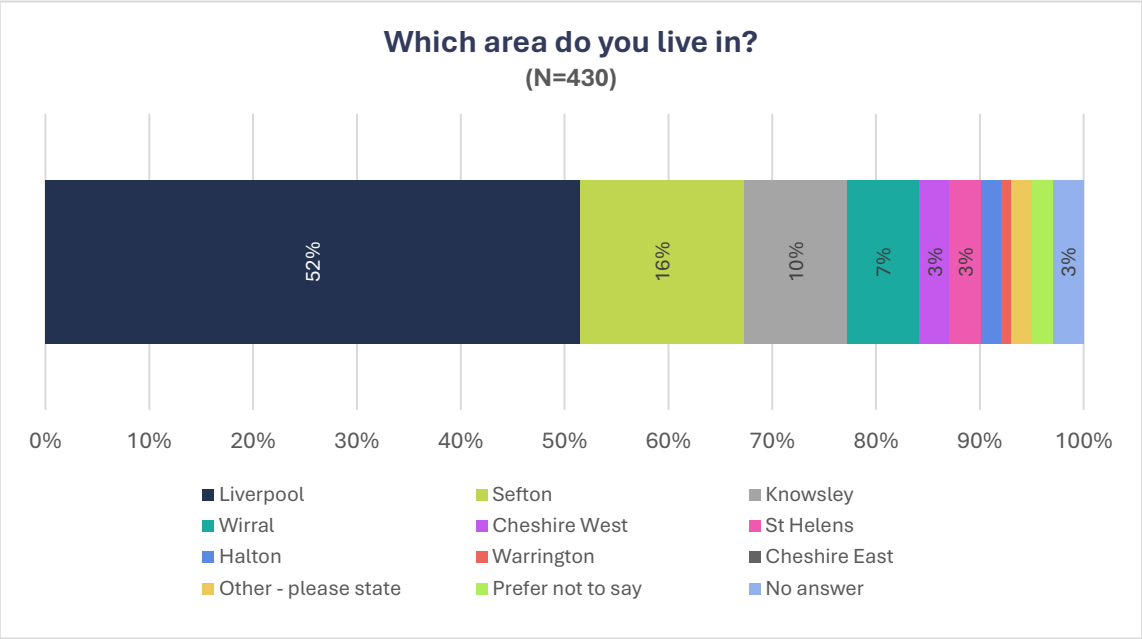

Chart 2: Which area do you live in?

Ethnicity

Among those who provided information on ethnicity, the majority identified as White (85%). The majority were English / Welsh / Scottish / Northern Irish / British, who accounted for 81% of respondents (see Chart 3).

Respondents of Mixed / Multiple ethnic groups represented 3% of respondents overall, including those identifying as White and Black Caribbean (1%), White and Black African (1%), and other Mixed backgrounds (1%).

Individuals from Asian backgrounds accounted for 2% of respondents, with the majority identifying as Indian and smaller numbers identifying as Bangladeshi, Chinese or Pakistani.

Respondents from Black / African / Caribbean / Black British backgrounds made up 1% of respondents, primarily those identifying as African (1%). A small number identified as Caribbean (less than 1%).

Less than 1% of respondents identified as Arab. A further 4% preferred not to disclose their ethnic background and 4% did not answer the question.

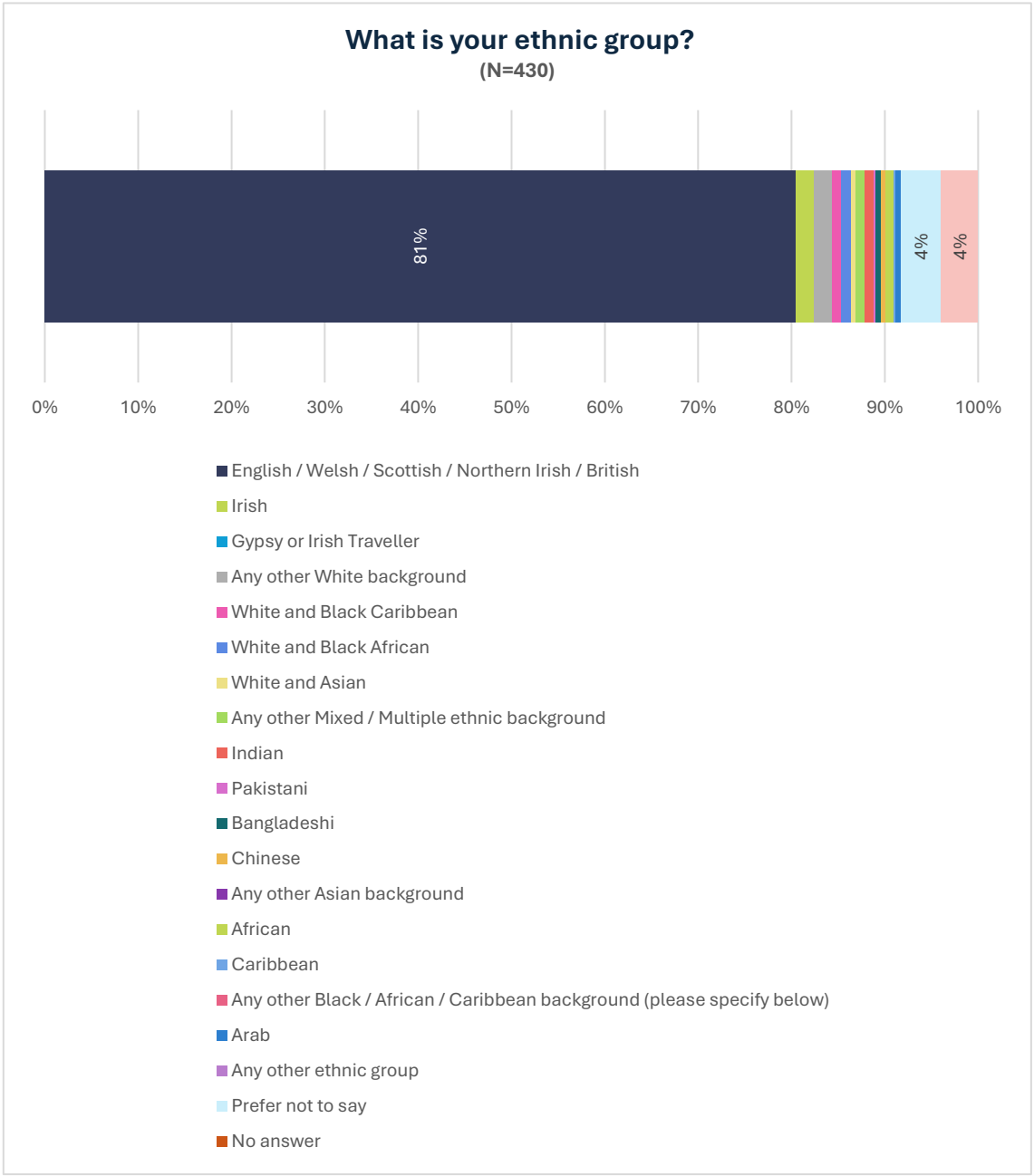

Chart 3: What is your ethnic group?

Age

The largest proportion of respondents was aged between 30 – 49 (48%), with 36% aged 50 or older and 9% under 30 (see Chart 4).

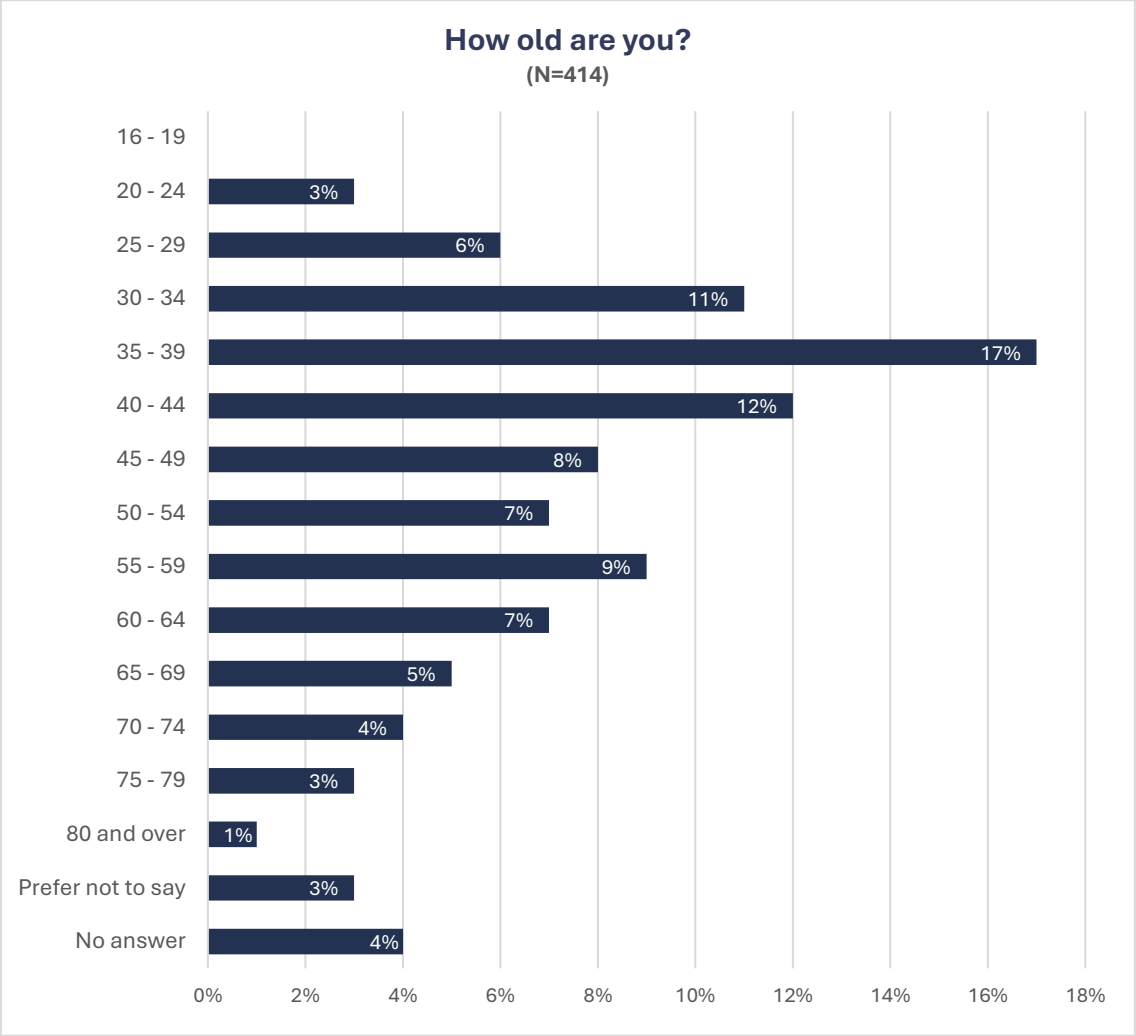

Chart 4: How old are you?

Religion

Christianity was the most commonly identified religion or belief, with 49% of respondents identifying as Christian. A further 40% stated that they had no religion.

Other religions were represented by relatively small proportions of respondents. Around 1% identified as Muslim and 1% as Jewish, while smaller numbers identified as Hindu or another religion. No respondents identified as Buddhist or Sikh.

A small proportion of respondents (6%) chose not to disclose their religion or belief while 3% did not answer the question (see Chart 5).

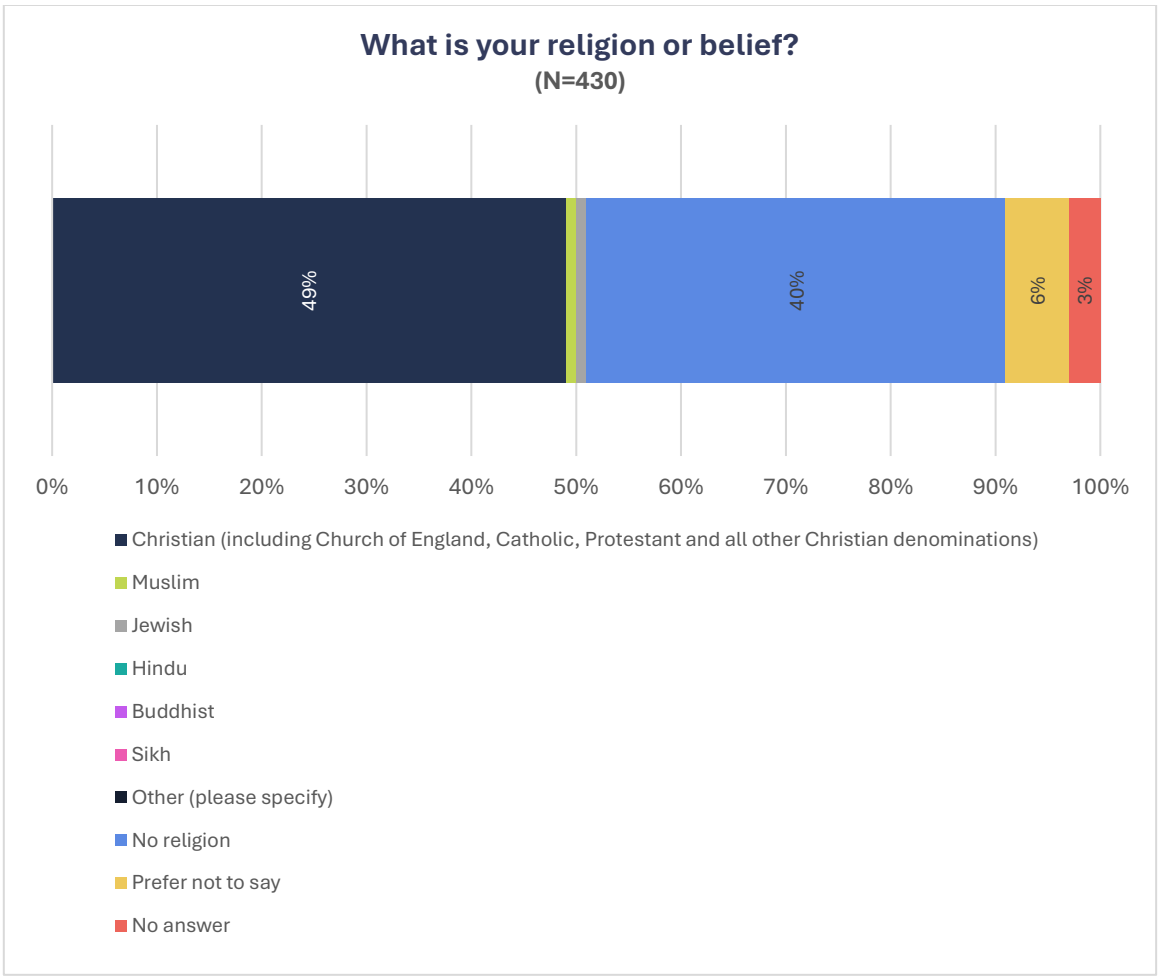

Chart 5: What is your religion or belief?

Gender and sexual orientation

In terms of gender, the majority of respondents identified as female (81%), with 12% identifying as male. A small number (less than 1%) identified as non-binary and gender-non-conforming, while 3% preferred not to say and 3% did not answer the question. (see Chart 6).

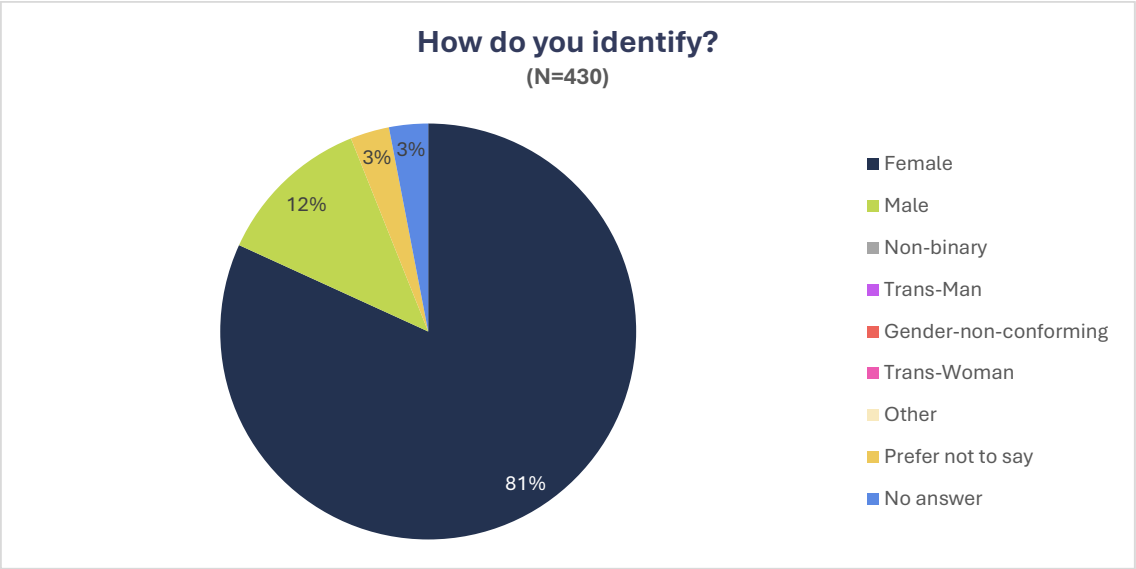

Chart 6: How do you identify?

Regarding sexual orientation, 81% of respondents identified as heterosexual, while the remainder included individuals identifying as lesbian, gay, bisexual, asexual, or other orientations (6%), with 10% opting not to disclose this information and 4% not answering the question (see Chart 7).

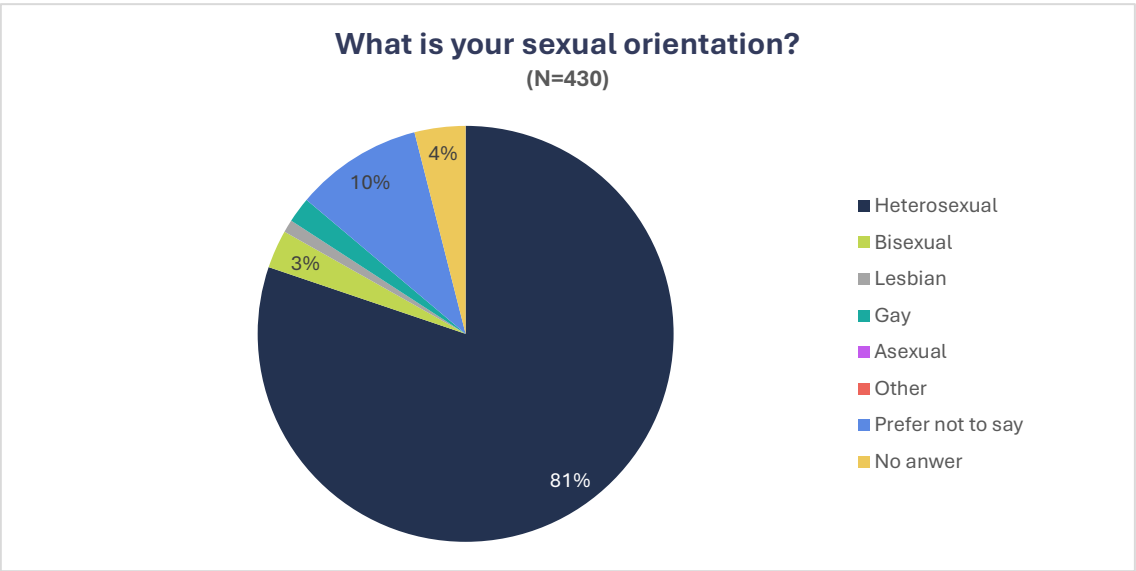

Chart 7: What is your sexual orientation?

Relationship status

Relationship status showed that half of respondents were married (50%), while 13% were single and 18% were living with a partner. Smaller proportions reported being in a civil partnership (1%), divorced (3%), separated (1%), or widowed (3%) (see Chart 8).

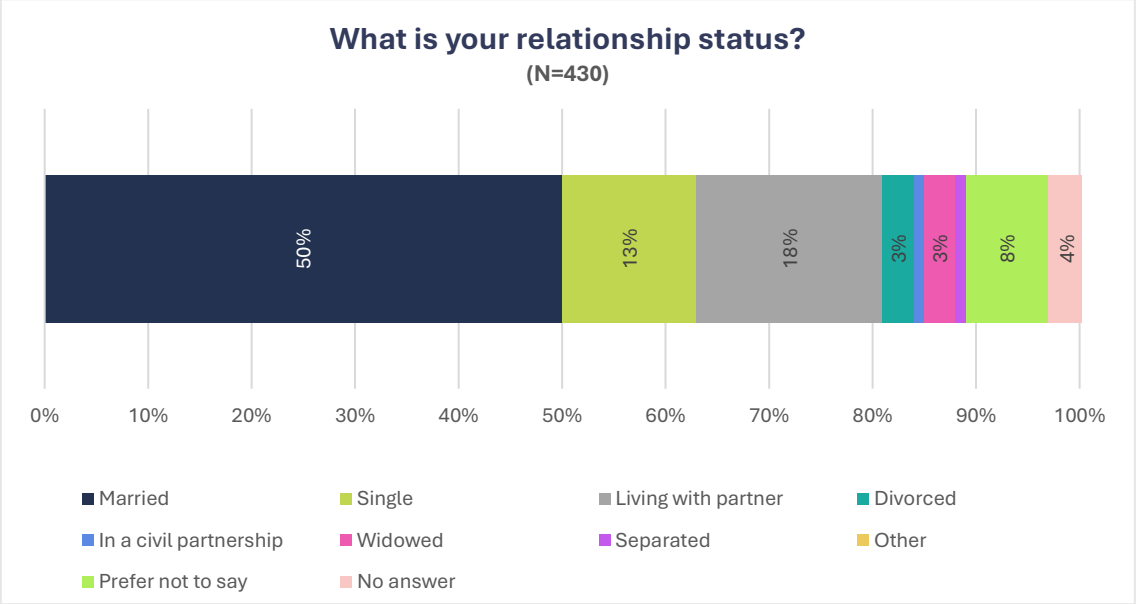

Chart 8: What is your relationship status?

Disability

Health-related questions revealed that 59% of people did not consider themselves to have a disability. Among those who reported a disability or health condition, physical disabilities were the most commonly cited, accounting for 11% of respondents. Long-term illnesses, such as cancer, diabetes or COPD, were reported by 8%, while 7% identified as having a mental health condition.

Smaller proportions of respondents reported a sensory disability (3%), or a learning disability or difficulty (3%). A further 4% selected another disability or health condition.

In addition, 10% of respondents preferred not to disclose whether they had a disability or health condition (see Chart 9).

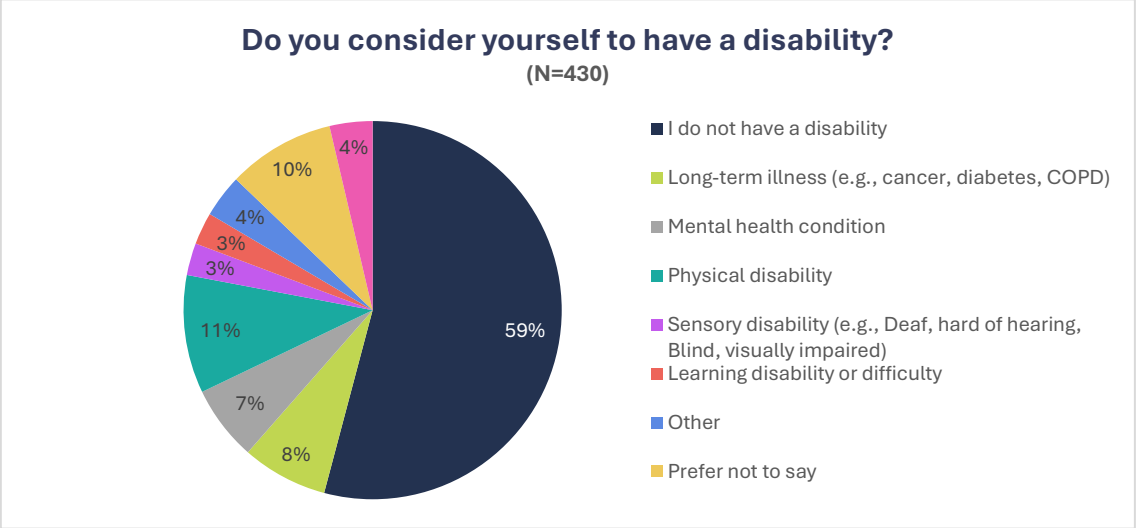

Chart 9: Do you consider yourself to have a disability?

27% of respondents reported limitations in day-to-day activities due to a health problem or disability which has lasted, or is expected to last, at least 12 months. This included 9% of respondents who reported that they were 'limited a lot' (see Chart 10).

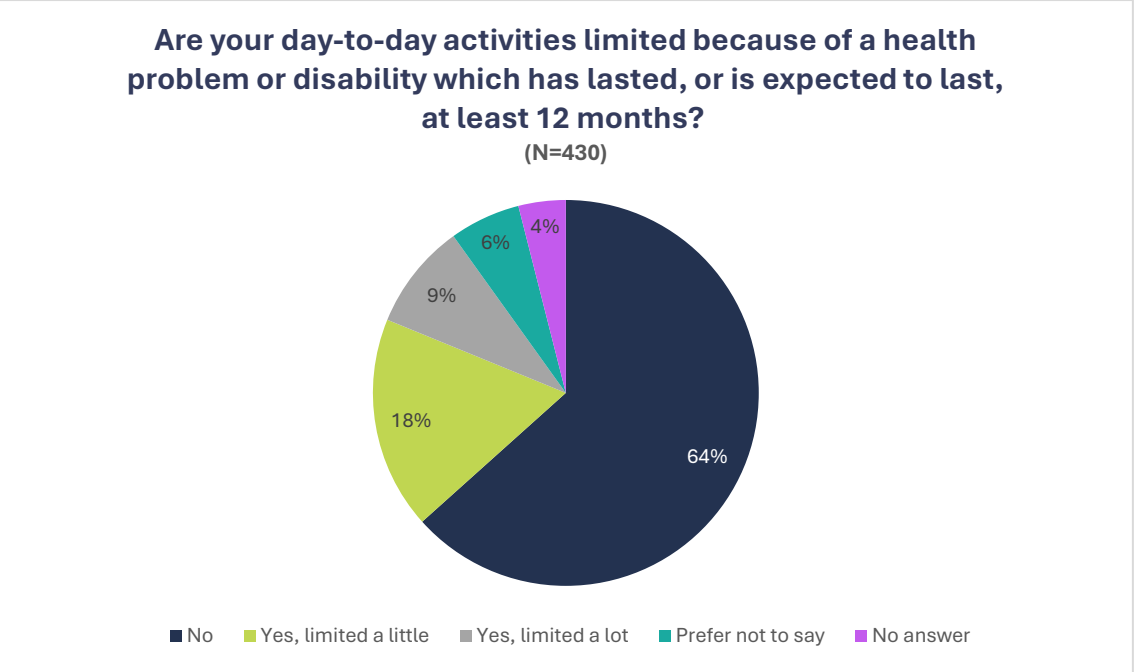

Chart 10: Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

Carer responsibilities

25% of respondents indicated that they care for someone, with 14% caring for young people (aged under 24), 10% caring for older adults (aged 50 and over), and 1% caring for adults aged 25 to 49 (see Chart 11).

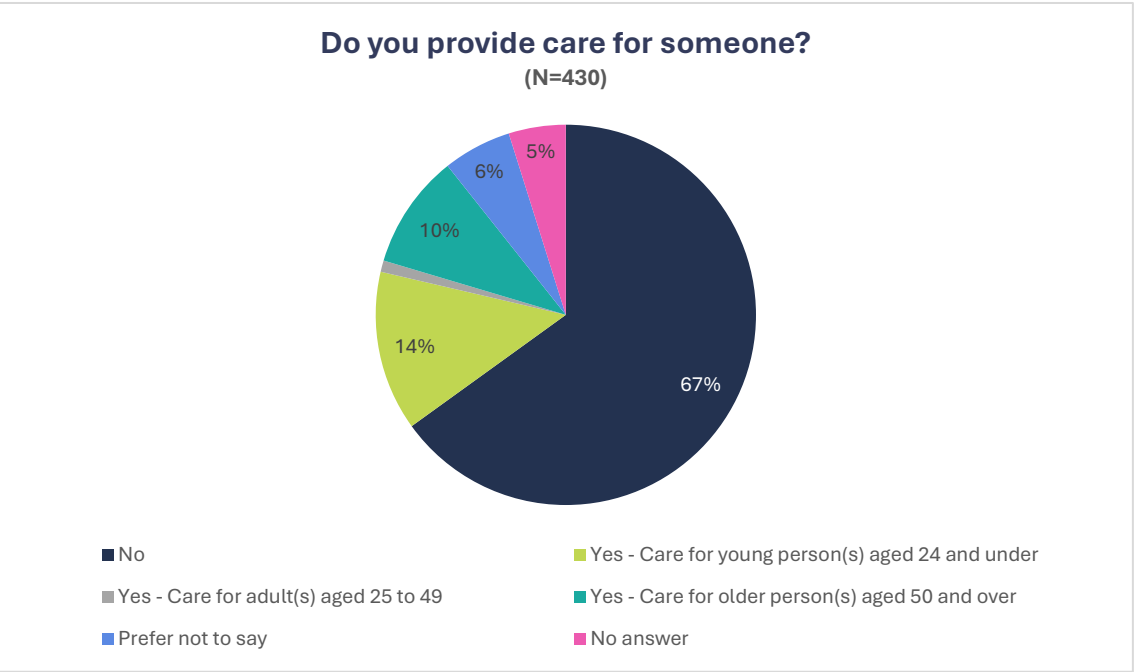

Chart 11: Do you provide care for someone?

Pregnancy and childbirth

Pregnancy and childbirth data showed that 9% of respondents were pregnant at the time of the survey, and 5% had given birth within the past six months (see Charts 12 and 13).

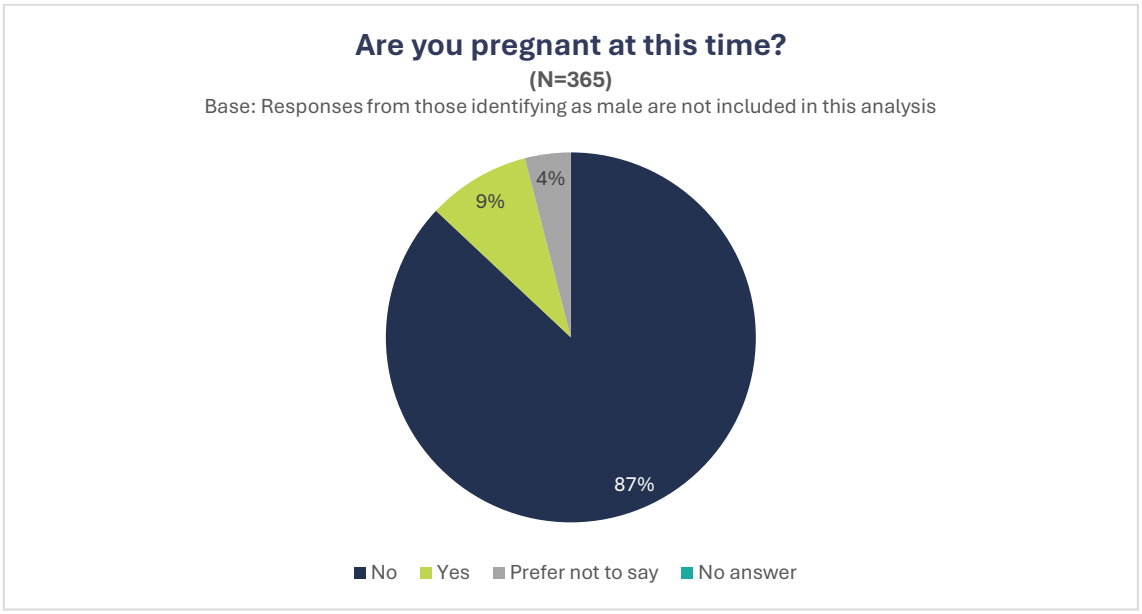

Chart 12: Are you pregnant at this time?

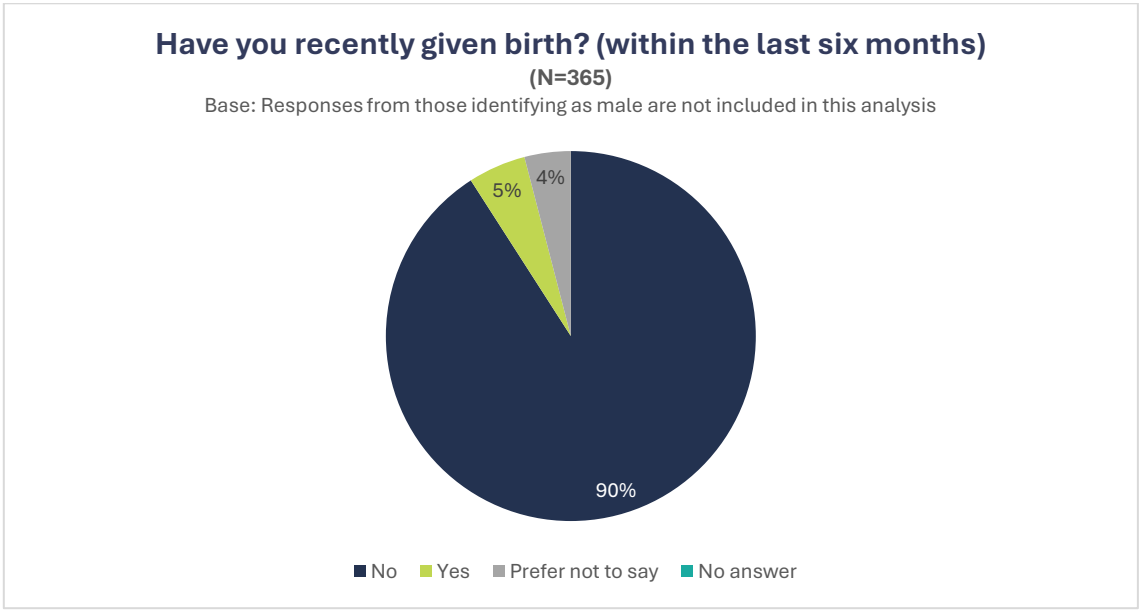

Chart 13: Have you recently given birth? (within the last six months)

Armed forces service

1% of respondents reported that they had served in the armed forces (see Chart 14).

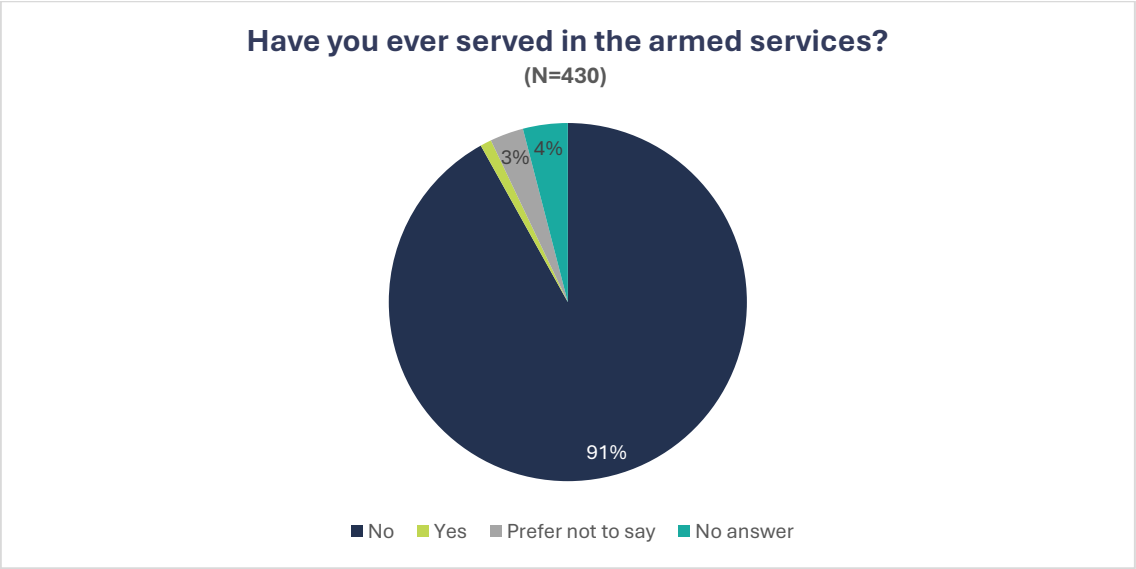

Chart 14: Have you ever served in the armed services?

Healthcare or social care professionals

49% of respondents indicated that they worked in healthcare or social care. Among the professionals who provided further information about their workplace:

- 49% work at NHS University Hospitals of Liverpool Group
- 7% at Mersey Care NHS Foundation Trust
- 5% at Alder Hey Children's Hospital NHS Foundation Trust
- 3% at NHS Cheshire and Merseyside

Smaller numbers of respondents indicated employment at a variety of other NHS Trusts and organisations, including GP practices, independent health or social care providers, and councils.

6% of professionals selected 'Other' and specified a wide range of roles and workplaces. These included colleagues from other NHS organisations, care homes, universities, and those who are retired (see Chart 15).

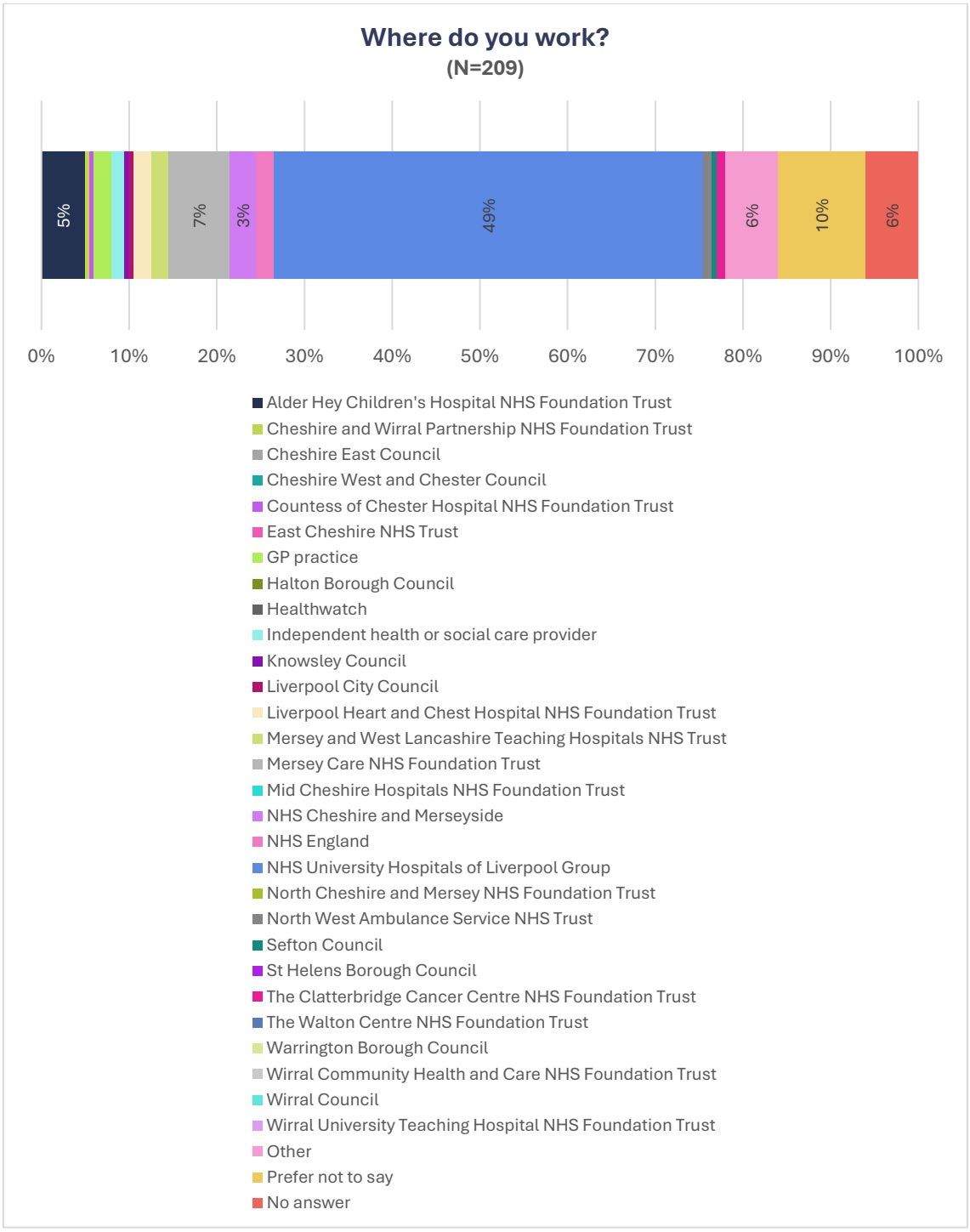

Chart 15: Where do you work?

How people found out about the questionnaire

Respondents were asked how they found out about the questionnaire.

Social media was the most prominent source, mentioned by 32% of participants, followed by email from the NHS (30%), the NHS website (11%), and word of mouth (10%) (see Chart 16).

Local media such as newspapers and radio accounted for 9%, while a small number of respondents mentioned hearing about the questionnaire through leaflets or flyers, Healthwatch organisations, or community and voluntary sector organisations (all 2%).

A smaller number of respondents mentioned a hospital volunteer, while a few indicated they did not know.

Within the 'Somewhere else' category, selected by 8% of respondents, people cited a number of different sources including their workplace and people campaigning for NHS services.

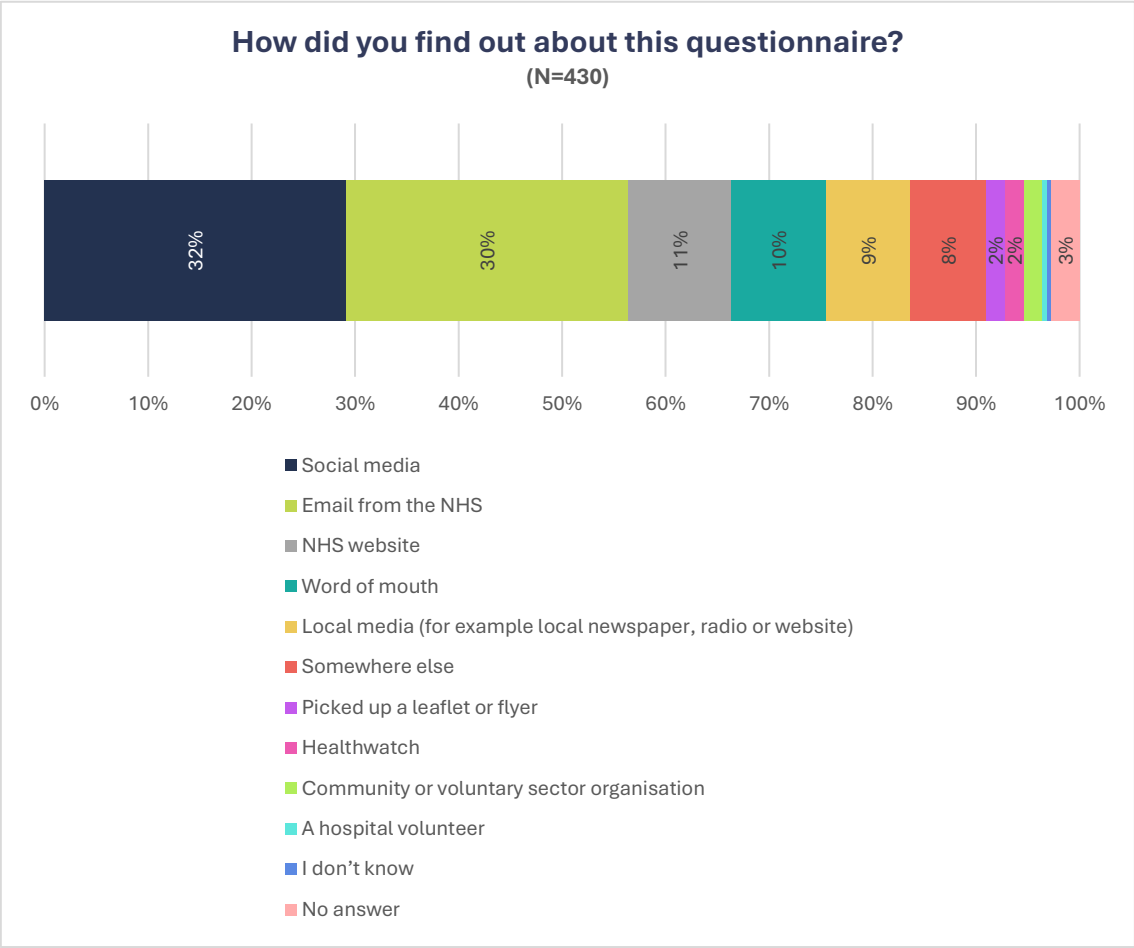

Chart 16: How did you find out about this questionnaire?

The numbers of people who accessed the engagement materials

The majority of respondents (57%) reported having read the 'Improving hospital gynaecology and maternity services in Liverpool' booklet. Additionally, 17% of respondents had engaged with the Easy Read version of the booklet, while 27% had visited the website www.GynaeAndMaternityLiverpool.nhs.uk for further information. A smaller percentage (5%) indicated that they had attended a public information event and 5% of respondents had attended an online briefing, meeting or group event (see Chart 17).

Among the respondents, 16% stated that they had not engaged with any of the provided resources.

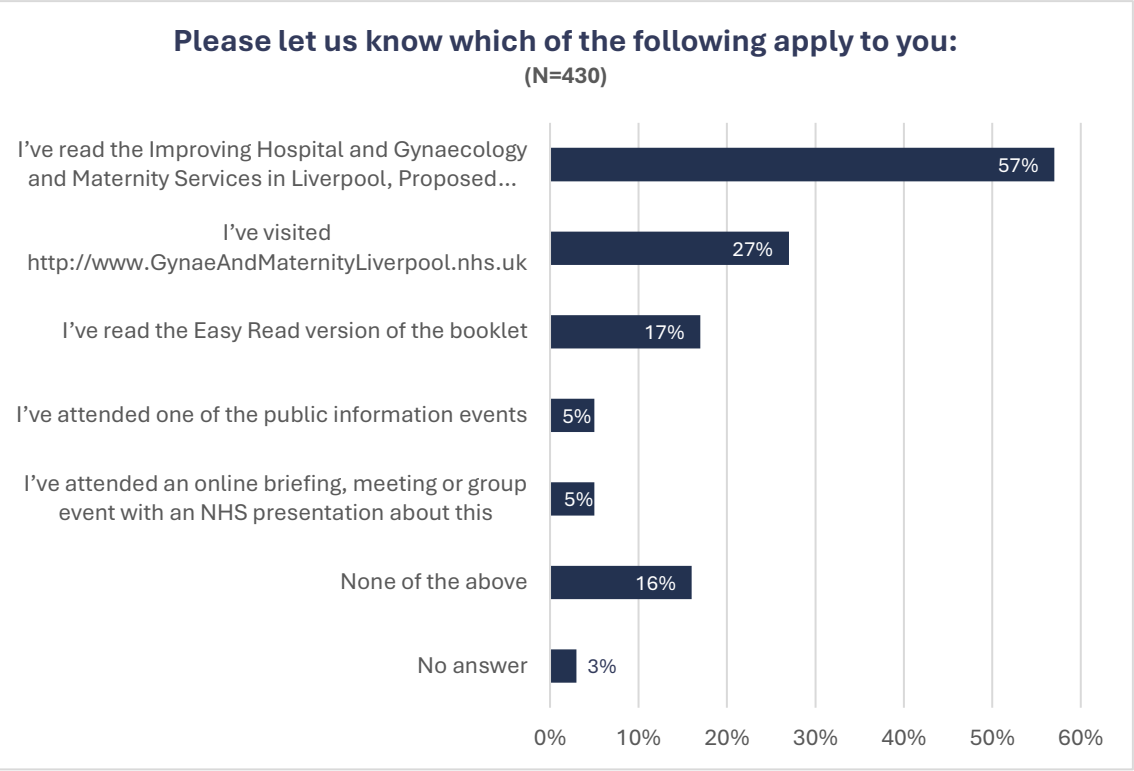

Chart 17: Please let us know which of the following apply to you

Appendix B: Engagement questionnaire

Improving Hospital Gynaecology and Maternity Services in Liverpool: Proposed changes to where high risk and complex care takes place

About this questionnaire

The NHS in Cheshire and Merseyside is looking at improving hospital gynaecology (care relating to any functions and diseases affecting the female reproductive system) and hospital maternity (care provided during pregnancy, delivery, and after birth) services in Liverpool.

The majority of this care currently happens at Liverpool Women's Hospital, which means they are separate from other adult hospital services such as intensive care, and other specialist teams. This situation can delay care and create problems getting women the treatment they need, particularly very seriously ill patients.

Because of this, we are proposing to move to treating a small number of the most complex and high-risk gynaecology and maternity cases at the Royal Liverpool University Hospital, rather than Liverpool Women's Hospital.

You can use this questionnaire to share your views about this proposal. We'll use the feedback we receive to help shape how we move forward.

You should read the *Improving Hospital and Gynaecology and Maternity Services in Liverpool - Proposed changes to where high risk and complex care takes place booklet* before answering the questions.

You can find the booklet at www.GynaeAndMaternityLiverpool.nhs.uk where you'll also find details of some public information events that we will be holding in June 2026.

If you would like to request this questionnaire, or the booklet, in a different language or another format, such as Easy Read or large print, please call 0151 702 4353 (Monday to Friday, between 8.30am and 4pm) or email engagement@cheshireandmerseyside.nhs.uk

Please return this questionnaire by midnight on Tuesday 14 July 2026.

How will my information be used?

NHS Cheshire and Merseyside Integrated Care Board (ICB), the organisation that plans health services for our area, has appointed an independent company, Hood & Woolf, to administer this questionnaire and report on the responses. Responses made in a personal capacity will be anonymous and you will not be identifiable. Responses made in an official capacity (e.g. if you are responding on behalf of an organisation or as an elected representative), may be attributed.

All the questions are optional, and all information you provide will be processed by the independent company in accordance with the latest data protection guidance. Information will only be used to share your views on hospital gynaecology and maternity services in Liverpool, and any personal information which could identify you will be kept for no more than one year. Please visit Hood & Woolf for more information.

Section 1. Your views about the proposed change

After reading the information in the ***Improving Hospital and Gynaecology and Maternity Services in Liverpool, Proposed changes to where high risk and complex care takes place booklet***, please answer the following questions.

1. The NHS is proposing that in the future, a small number of the most high-risk and complex births and gynaecology operations would take place at the Royal Liverpool Hospital instead of Liverpool Women's Hospital.

We believe this proposed change would affect around 150 women each year. More information about this is available in ***Improving Hospital and Gynaecology and Maternity Services in Liverpool, Proposed changes to where high risk and complex care takes place booklet***.

To what extent do you agree or disagree with the proposal?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

2. Please explain your answer to the previous question and/or outline any impacts of the option proposed, and how you think any disadvantages could be addressed:

3. The NHS must consider the impact of decisions on people with protected characteristics under the Equality Act 2010 (age, disability, sex, gender reassignment, marriage and civil partnership, pregnancy, maternity, race, religion or belief and sexual orientation).

Are there any positive or negative impacts that you believe should be taken into account in relation to equalities?

If so, please provide any supporting evidence and suggest how the NHS could reduce any potential negative impacts or increase any positive impacts.

4. Do you have any other comments that you've not already made?

   This might include comments on the proposal or any other alternative solutions to address the challenges that you think the NHS should consider.

Section 2 - Your experiences

5. Have you, or someone close to you, ever had a high-risk and complex birth and/or gynaecology operation moved from Liverpool Women's Hospital to another hospital, because more specialist or emergency care was needed?

   This could include having a birth or surgery moved to another hospital in advance, or being moved to another hospital by ambulance in an emergency situation.

   - Yes – I experienced a planned move of care
   - Yes – I experienced an emergency or unplanned move of care
   - Yes – someone close to me experienced a planned move of care
   - Yes – someone close to me experienced an emergency or unplanned move of care
   - No
   - Not sure

   If you would like to, please tell us about this experience, including anything that worked well or could have been improved.

6. **Have you, or someone close to you, used hospital gynaecology and/or hospital maternity services in Liverpool?**

   The majority of this care happens at Liverpool Women's Hospital – we aren't referring to any maternity and gynaecology services that take place at other local hospitals including Whiston Hospital, Ormskirk Hospital, or Wirral Women and Children's Hospital (Arrowe Park).

Please tick all boxes that apply.

I have used/am using hospital gynaecology services in Liverpool	
I have used/am using hospital maternity services in Liverpool	
Someone close to me has used/is using hospital gynaecology services in Liverpool	
Someone close to me has used/is using hospital maternity services in Liverpool	
I work in – or alongside – hospital gynaecology and/or maternity services in Liverpool	
I want to share my views, but I haven't had any experience of using these services in Liverpool.	
Not applicable – I am providing a response in an official capacity (e.g. if you are responding on behalf of an organisation or as an elected representative)	

If 'not applicable' is selected, please tell us your:

- Name
- Job title
- Organisation or area you represent
- And if/how you gathered views of your constituents or members

Section 3 – About you

7. **How did you find out about this questionnaire?** Please tick all boxes that apply.

Picked up a leaflet or flyer	
Social media	
NHS website	
A hospital volunteer	
Local media (for example local newspaper, radio or website)	
Word of mouth	
Healthwatch	
Community or voluntary sector organisation	
Email from the NHS	
I don't know	

If you found out somewhere else, please let us know where:

8. Please let us know which of the following apply to you:

I've read the *Improving Hospital and Gynaecology and Maternity Services in Liverpool, Proposed changes to where high risk and complex care takes place booklet*	
I've read the Easy Read version of the booklet	
I've visited www.GynaeAndMaternityLiverpool.nhs.uk	
I've attended one of the public information events	
I've attended an online briefing, meeting or group event with an NHS presentation about this	
None of the above	

If you are providing your own personal response, please answer the questions below. These questions are optional, but they will help us understand more about who we're reaching with our engagement activity.

9. What is the start of your postcode? (For example, L8 7 or L19 2)

☐☐☐☐ ☐■■

10. Which area do you live in?

Cheshire East	
Cheshire West	
Halton	
Knowsley	
Liverpool	
Sefton	
St Helens	
Warrington	
Wirral	

Other – please state:

11. Are you a healthcare or social care professional?

Yes	
No	

If 'yes' is selected, **where do you work?**

Alder Hey Children's Hospital NHS Foundation Trust
Cheshire and Wirral Partnership NHS Foundation Trust
Cheshire East Council
Cheshire West and Chester Council
Countess of Chester Hospital NHS Foundation Trust
East Cheshire NHS Trust
GP practice
Healthwatch
Halton Borough Council
Independent health or social care provider
Knowsley Council
Liverpool City Council
Liverpool Heart and Chest Hospital NHS Foundation Trust
Mersey Care NHS Foundation Trust
Mid Cheshire Hospitals NHS Foundation Trust
Mersey and West Lancashire Teaching Hospitals NHS Trust
NHS Cheshire and Merseyside
NHS England
NHS University Hospitals of Liverpool Group
North Cheshire and Mersey NHS Foundation Trust
North West Ambulance Service NHS Trust
Sefton Council
St Helens Borough Council
The Clatterbridge Cancer Centre NHS Foundation Trust
The Walton Centre NHS Foundation Trust
Warrington Borough Council
Wirral Community Health and Care NHS Foundation Trust
Wirral Council
Wirral University Teaching Hospital NHS Foundation Trust
Other (please state):

Section 4. Equality monitoring

We are asking these questions because we want to make sure that we have asked lots of different people for their views.

All the information that you give will be recorded and reported anonymously – it will never be used with your name or contact details. NHS Cheshire and Merseyside collect this as part of its duty under the Equality Act 2010.

Your data will be treated confidentially and stored in accordance with Data Protection law and Hood & Woolf's privacy notice at www.hoodwoolf.co.uk/privacy-policy/

You do not have to answer these questions if you do not want to.

12. What is your ethnic group? Choose one option that best describes your ethnic group or background.

White: English/Welsh/Scottish/Northern Irish/British	
White: Irish	
White: Gypsy or Irish Traveller	
White: Any other White background (please specify below)	
Mixed/Multiple ethnic groups: White and Black Caribbean	
Mixed/Multiple ethnic groups: White and Black African	
Mixed/Multiple ethnic groups: White and Asian	
Mixed/Multiple ethnic groups: Any other Mixed/Multiple ethnic background (please specify below)	
Asian/Asian British: Indian	
Asian/Asian British: Pakistani	
Asian/Asian British: Bangladeshi	
Asian/Asian British: Chinese	
Asian/Asian British: Any other Asian background (please specify below)	
Black/African/Caribbean/Black British: African	
Black/African/Caribbean/Black British: Caribbean	
Black/African/Caribbean/Black British: Any other Black/African/Caribbean background (please specify below)	
Other ethnic group: Arab	
Prefer not to say	

Any other ethnic group (please specify below):

13. How old are you?

16 - 19		55 - 59	
20 - 24		60 - 64	
25 - 29		65 - 69	
30 - 34		70 - 74	
35 - 39		75 - 79	
40 - 44		80 and over	
45 - 49		Prefer not to say	
50 - 54			

14. What is your religion or belief?

No religion	

Christian (including Church of England, Catholic, Protestant and all other Christian denominations)	
Buddhist	
Hindu	
Jewish	
Muslim	
Sikh	
Prefer not to say	
Other: (please specify)	

15. How do you identify?

Male	
Female	
Trans-Man	
Trans-Woman	
Non-binary	
Gender-non-conforming	

Prefer not to say	
Other (please specify):	

16. What is your sexual orientation?

Heterosexual	
Lesbian	
Gay	
Bisexual	
Asexual	

Prefer not to say	
Other (please specify):	

17. What is your relationship status?

Married	
In a civil partnership	
Single	
Divorced	
Living with partner	
Separated	

Widowed	
Prefer not to say	
Other (please specify)	

18. Are you pregnant at this time?

The Equality Act 2010 protects people who are pregnant or have given birth within a 26-week period.

Yes	
No	
Prefer not to say	

19. Have you recently given birth? (within the last six months)

The Equality Act 2010 protects people who are pregnant or have given birth within a 26-week period.

Yes	
No	
Prefer not to say	

20. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

Yes, limited a lot	
Yes, limited a little	
No	
Prefer not to say	

21. Do you consider yourself to have a disability? The Equality Act 2010 states a person has a disability if they have a physical or mental impairment that has a 'substantial' and 'long-term' (more than 12 months) negative effect on your ability to do normal daily activities.

Physical disability	
Sensory disability (e.g., Deaf, hard of hearing, Blind, visually impaired)	
Mental health condition	
Learning disability or difficulty	
Long-term illness (e.g., cancer, diabetes, COPD)	

Prefer not to say	
Other (please specify):	

22. Do you provide care for someone? A carer is defined as anyone who cares, unpaid (or in receipt of Carer's Allowance, but not someone who is employed as a care professional), for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support.

Yes - Care for young person(s) aged 24 and under	
Yes - Care for adult(s) aged 25 to 49	
Care for older person(s) aged 50 and over	

No	
Prefer not to say	

23. Have you ever served in the armed services?

Yes	
No	
Prefer not to say	

Thank you very much for your time.

We will use your feedback to help shape how we move forward.

If you'd like to be kept up to date with this work, please sign-up to the virtual reference group to receive further email updates at: www.GynaeAndMaternityLiverpool.nhs.uk/get-involved/

If you are completing a hard copy, please return your questionnaire using the FREEPOST envelope provided. The closing date for us to receive your response is midnight on **Tuesday 14 July 2026**. Please allow 3 working days for your response to reach us.

Meeting of the Board of NHS Cheshire and Merseyside

26 November 2026

Update on National Maternity Reviews

Agenda Item No: ICB/11/26/26/09

Responsible Director: Fiona Lemmens – Executive Clinical Director

REPORT SUMMARY SNAPSHOT

Required Information	Details			
Responsible Executive Director	Fiona Lemmens - Executive Clinical Director			
Report approval	**By**	Fiona Lemmens Executive Clinical Director		
	Date	18/11/26		
Presented by	Fiona Lemmens – Executive Clinical Director			
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*	P4, P11,P12, P14, P15, P16, P17			
Financial Implications*	**Yes**		**No**	✓
	If Yes:			
	Have the financial implications been reviewed by the Director of Finance			
	Has a budget been identified			
Legal Implications*	None at this stage			
Conflicts of Interest associated with this report	None			
Impact assessments undertaken*	**Equality**			N/A
	Quality			N/A
	Data			N/A
	Sustainability			N/A
Public or Clinical engagement undertaken	There is national work on patient and staff engagement taking place. Future C&M engagement will be based on the recommendations of the national taskforce report.			

1. Purpose of the report

Further to our initial discussion at September Board this report provides an interim update for the Board on the C&M system response to the National Maternity and Neonatal Investigation led by Baroness Amos and the Nottingham Ockenden review.

2. Ask of the Board

The Board is asked to:

- Note and comment on the content of this report.

3. Executive summary

The Amos investigation provides a national blueprint for maternity and neonatal reform. The Nottingham Ockenden review demonstrates the consequences when concerns from women and families are dismissed, governance and clinical leadership are weak, workforce pressure is normalised, culture prevents challenge, and learning is not translated into sustained improvement.

Both reports reinforce that the central challenge is no longer identifying recommendations, but ensuring consistent implementation, accountability, and demonstrable impact.

The direction from the NHSE national team is for providers to proceed now with the 10 urgent actions in the Maternity and Neonatal 10-Point Plan (Appendix 1) while the National Maternity Taskforce undertakes its wider review and develops the longer-term national response. C&M Providers have submitted their initial assessment against the 10-point plan, and the ICB Womens Health and Maternity team have completed an initial independent review of the evidence which was then submitted to the NHSE regional team within required timeframe. The ICB Quality and Performance Committee is due to receive a detailed report on the information gathered in these initial assessments.

4. Amos Investigation

The Amos investigation asked why avoidable maternal and neonatal deaths and harm continue despite repeated national reviews. It engaged more than 450 families, 10,500 public responses and 9,000 staff, and identified fragmentation, complexity, weak learning, and insufficient accountability.

Its principal national recommendations include a statutory Maternity and Neonatal Commissioner, a Modern Service Framework, listening to women as a safety metric,

treating racism and inequality as patient safety issues, stronger investigations after harm, strengthened leadership and culture, and investment in digital infrastructure and estates.

5. Nottingham Ockenden review

The Nottingham review considered care from 2012 to 2025 and involved more than 2,500 families. It identified longstanding failures in governance, clinical leadership, incident investigation, workforce, culture and listening to women and families.

Providers have been asked to read and understand the findings and undertake gap analysis against the immediate and essential actions while awaiting coordinated national direction. The report's themes closely align with the Amos investigation.

6. Immediate 10-Point Plan and reporting approach

The direction from the NHSE national team is for providers to proceed now with the 10 urgent actions in the Maternity and Neonatal 10-Point Plan while the national Maternity Taskforce undertakes its wider review and develops the longer-term national response. Providers and systems are advised not to defer local action pending that review.

These urgent actions provide the interim assurance and improvement framework for the C&M system while the National Maternity Taskforce completes its review and develops the longer-term implementation response to the Amos and Ockenden findings. That report is anticipated to be published in December 2026.

The 10-point plan translates the national findings into urgent expectations on Martha's Rule, real-time family voice and audit, dual Board accountability, staff listening, inequalities, 24/7 safety and responsiveness, homebirth, humane and candid responses following harm, maternity triage, and post-death care. Action 4: Amos into action' staff listening exercise, is being delivered nationally and was not included in the provider compliance review. The remaining actions were expanded into 26 assessable deliverables. Provider self-assessment baseline returns were due in September 2026, and progress returns are due by 31 December 2026.

7. Proposed C&M follow-up and governance

The September 2026 baseline is an important first step and the immediate priority will be to convert any partial compliance and narrative plans into Board-owned improvement delivery plans.

The December progress return should therefore focus on movement in the highest-risk deliverables, closure of evidence gaps and explicit escalation where residual risk remains. This approach ensures that immediate safety improvement continues locally

while C&M providers remain ready to align with any further requirements arising from the National Maternity Taskforce review.

The ICB Quality and Performance Committee is due to receive a detailed report on the information gathered in these initial assessments. Future updates on the December submissions and any subsequent requirements will be reported through the Quality and Performance Committee.

APPENDIX 1

Ten Point Plan for Maternity and Neonatal Services

A set of urgent actions in response to the recommendations in the Amos Report and Ockenden Report that NHSE are asking trusts and the wider system to prioritise.

Listening to women and their families by rolling out Martha's Rule

- Commence roll out of Martha's Rule across all maternity and neonatal services in 2026/27.
- Building on the learning and insights from the recent pilot, this next phase will support implementation in all antenatal, intrapartum and postnatal inpatient maternity and obstetric settings, including maternity triage and assessment units, and neonatal settings.
- Implementation will be led by the national Martha's Rule programme team, working closely with patient safety collaboratives to provide coordinated local support, webinars, guidance and advice. We will contact provider organisations in the coming weeks to confirm expectations, resources and timelines.

Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit data that are acted upon at board level

- All trusts should implement a monthly cycle of collecting and analysing real-time patient outcomes and experience data at their public boards, using locally meaningful measures like the friends and family test, selected elements of PREM (when available) and insights from maternity and neonatal voices partnerships (MNVPs). This should include regularly listening to women, families and neonatal parents at different points in the pathway, publishing data and patient commentary for full transparency, and ensuring a clear focus on the experiences of people from minority backgrounds. This will ensure the voices and experiences of women and families are heard, scrutinised and acted upon by boards.
- As part of this, trusts should also reinvigorate clinical audits focusing on key and relevant recommendations identified in the Ockenden and Amos reviews in a focused and effective way, and act on the findings.
- The aim is to support this approach through national webinars.

Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care

- All trusts must establish clear joint accountability at board level for maternity and neonatal services, with medical directors and chief nurses holding shared responsibility for oversight, performance and improvement. This must include consistent medical director engagement alongside the chief nurse, and parity between obstetric, midwifery, neonatal and operational leadership. Directors of midwifery and clinical directors leading maternity and neonatal services should attend boards when maternity or neonatal matters are discussed.

- This should also be implemented across all levels in the NHS including at system, regional, and NHS England boards to eliminate siloed working and strengthen system-wide leadership.

'Amos into action' staff listening exercise

- Following the listening conversation undertaken by Baroness Amos to understand the nature of the issues in maternity and neonatal services, NHS England will launch a full, open conversation with NHS staff and leaders to identify how the recommendations can be implemented across the system.
- It will explore and help address the role of culture, attitudes, approaches to practice and ways of working – bringing staff into the single largest national conversation about what trusts and individual clinicians need to do differently to implement both the letter and spirit of the Amos recommendations. This will be done in a way that aligns to rather than duplicates the work of the taskforce and will report findings into it. It will focus on how we implement Baroness Amos's findings from the listening exercise and the findings of the Ockenden review of Nottingham University Hospitals NHS Trust (NUH).

Addressing inequalities in maternity and neonatal outcomes

- We can now confirm the timeline for national rollout of the Perinatal Equity and Anti-discrimination Programme, which will be available to all trusts by the end of 2026. The programme has been developed to support maternity and neonatal teams to tackle racism and discrimination, improve the experiences and outcomes of ethnic minority groups and those from deprived communities, and support staff to work in environments free from discrimination and racism. All boards must ensure that provision is in place to allow enough staff to be released to complete the Perinatal Equity and Anti-discrimination Programme, with full participation expected across multi-disciplinary teams.
- Boards must also regularly review and act on trends identified by their inequalities data dashboards: Maternity and Neonatal Equalities dashboard – NHS England Digital All NHS trusts providing maternity services are responsible for fully implementing the Maternal Care Bundle by March 2027. This includes providing regular reports to the trust board on implementation.

Ensuring 24/7 safety and responsiveness of maternity and neonatal services

- All boards must take accountability for ensuring safe and effective service arrangements, including reviewing staffing to ensure 24/7 availability and responsiveness across key workforce groups.
- Boards must also review internal resource deployment and consider whether roles not directly supporting frontline delivery can be redirected to strengthen service provision. Trusts must ensure that, where specialist posts exist (including in bereavement care and infant feeding), other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available.
- Commissioners also hold responsibility for ensuring that their maternity and neonatal service model aligns to local demographic needs. Boards and commissioners must

address local gaps and eliminate siloed working to ensure services can consistently and safely respond to the needs of women, babies and families.

Trusts to review their homebirth services

- Trusts have a continuing responsibility to offer homebirth as a choice for women and are responsible for ensuring that they manage their workforce to enable this. In November 2025, the Chief Midwifery Officer for England asked trusts to urgently review the safety and quality of their homebirth services.
- Trusts should ensure that this review has been undertaken and reported to their board and that any safety concerns requiring urgent attention have been actioned. They should ensure that improvement plans are in place where necessary and that risks have been communicated to their regional NHS England team.
- NHS England is working with partners to develop homebirth standards and a homebirth framework, to support women's autonomy, choice and personalised care, and to help services provide safe homebirth care.

Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach

- Trust boards should review how they are responding to patient safety incidents, complaints and concerns within maternity and neonatal services, with openness, humanity and candour.
- We will work with trusts, in alignment with the work of the national taskforce, to develop a blueprint for how organisations and leaders can respond with more humanity and compassion when things go wrong with a patient's care.

Deliver safe and effective triage in maternity services (already committed by Government)

- All trusts must commit to delivering safe and effective triage, starting by completing a board-level audit within 3 months, with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced. This will be supported by new NHS England guidance, which will be published this week.
- This includes having dedicated midwifery staffing to answer calls and provide face-to-face assessments, separate from other services such as the labour ward. Services should also have enough clinical, antenatal and bed capacity, with clear escalation routes in place at all times, including overnight and at weekends.
- Boards should have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes. Triage records should capture women's preferences, and services should use evidence-based standards, such as BSOTS, supported by rapid assessment training for triage midwives. This should enable trusts to identify risks, address delays and provide women with timely, consistent and high-quality triage care.
- The outcomes of this audit should be reported to regions and the Department of Health and Social Care / NHS England. Within 12 months, trusts must implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS.

- National maternity triage principles and a supporting measurement framework will be provided to trusts this week to reduce unwarranted variation, strengthen consistency in how concerns are assessed and escalated, and provide a clearer basis for local, regional and national improvement.

Post death care (already committed by Government)

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

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

26 November 2026

Cheshire and Merseyside Maternity Services Review

Agenda Item No: ICB/11/26/26/09

Responsible Director: Fiona Lemmens – Executive Clinical Director

REPORT SUMMARY SNAPSHOT

Required Information	Details			
Responsible Executive Director	Fiona Lemmens Executive Clinical Director			
Report approval	**By**	Fiona Lemmens Executive Clinical Director		
	Date	18/11/26		
Presented by	Fiona Lemmens – Executive Clinical Director			
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*	P4, P11, P12, P14, P15, P16, P17			
Financial Implications*	**Yes**		**No**	✓
	If Yes:			
	Have the financial implications been reviewed by the Director of Finance			
	Has a budget been identified			
Legal Implications*	Not at this stage			
Conflicts of Interest associated with this report	None			
Impact assessments undertaken*	**Equality**			×
	Quality			×
	Data			×
	Sustainability			×
Public or Clinical engagement undertaken	Ongoing engagement has been undertaken as BAU and for other interdependent reviews but no formal engagement for this review at this stage however patient and lived experience input will form part of the review process			

1. Executive Summary

The Board is asked to endorse a system-wide review of maternity services across Cheshire and Merseyside, in line with the draft Terms of Reference (Appendix 1).

Maternity services are critical to population health, influencing safety, health inequalities, and maternal and early years outcomes. While performance in maternity services across the region has improved over the past decade, significant challenges remain including inconsistencies in outcomes, service user experience, access, workforce capacity and sustainability, infrastructure, and financial resilience. The system is also experiencing changing demand patterns, with increased clinical complexity and acuity alongside declining birth rates resulting in reduced activity across providers, with some services now operating at lower volumes, potentially contributing to variation in service delivery and sustainability.

In response, the proposed review will:

- Establish a baseline of current services considering variation, risk, and performance.
- Identify gaps against national standards and best practice.
- Develop evidence-based recommendations for future service configuration and commissioning.
- Inform ICB commissioning intentions, investment decisions, and assurance processes.

2. Ask of the Board and Recommendations

2.1. The Board is asked to:

Endorse the proposed system wide review of maternity services as outlined in the paper and terms of reference.

3. Introduction / Background

Maternity services across Cheshire and Merseyside are safety-critical services that play a fundamental role in population health, health inequalities, maternal and early years outcomes. Cheshire and Merseyside overall performance & outcomes have improved significantly over the past ten years however the system continues to experience pressures in ensuring consistency in outcomes, experience, access, workforce, workforce sustainability, estate and financial resilience despite interventions and oversight from the Local Maternity and Neonatal System (LMNS) over the past few years. These pressures are expected to be further impacted by the change in role and function of the ICB and the continued national spotlight on maternity and neonatal services in the light of national reviews such as Ockendon, Thirlwall and Amos, mortality data from MBRRACE and

the recommendations from the new National Taskforce on Maternity Services.

Clinical complexity and acuity have increased while birthrates have reduced nationally, and this is reflected across Cheshire and Merseyside. Table 1 shows a comparator between deliveries by maternity providers in 2013/14 and 2024/25*. Despite a reduction in the numbers of providers (Independent and Community) and a merged Trust at Mersey and West Lancashire Teaching Hospital (MWL), the percentage of births has reduced across all sites with some showing less than two thousand births per annum.

Table 1

Cheshire & Merseyside Maternity Birth Data Comparator

Provider	Deliveries 2013/14	Total Births 2024/25
Countess of Chester Hospital NHS FT	3,092	1,880
East Cheshire NHS Trust	1,903	1,225
Liverpool Women's NHS FT	8,136	6,275
Mid Cheshire Hospitals NHS FT	2,759	2,500
Warrington and Halton Hospitals NHS FT	3,155	2,495
Wirral University Teaching Hospital NHS FT	3,350	2,855
Bridgewater Community Healthcare NHS FT	1,630	n/a
One to One Midwives	859	n/a
Southport & Ormskirk Hospital NHS Trust	2,857	
St Helens & Knowsley Teaching Hospitals NHS Trust (Whiston)	3,619	
MWL	n/a	5145
Total	**31,360**	**22,375**

2013/14 Deliveries: Office for National Statistics (ONS)

2024/25 Total Births: Maternity Services Data Set (MSDS), Cheshire & Merseyside Regional Maternity Report (rounded figures)

*Some data reporting issues may exist, and information is included to reflect a national trend of decreasing birth rates

More recently the role of ICBs has changed with the introduction of the model blueprint with more focus on strategic commissioning and the need for contract management of commissioned services to include:

- Effective planning, improvement, and quality assurance processes.
- Identification of unwarranted variation and risk in various parts of the system and potential mitigations.
- Supporting resource allocation to where it will have the greatest impact (allocative efficiency).

The review will therefore:

- Establish a baseline of current services considering variation, risk, and performance.
- Identify gaps against national standards and best practice.
- Produce evidence-based recommendations for the future

configuration and commissioning of services.
- Inform ICB commissioning intentions, investment priorities, and assurance arrangements.

4. Strategic Context and Rationale

The review is taking place within a complex and high-profile national and system context, including:

- Increased national focus following Ockenden and Amos reviews, and the Thirlwall Enquiry
- Evidence from MBRRACE mortality data
- Increased scrutiny through national maternity transformation and safety programmes

Locally, the review aligns with major system transformation programmes, including:

- Shaping Care Together (Sefton)
- Women's Hospital Services in Liverpool Programme: Case for Change and Options Appraisal
- NHS Specialised Commissioning Northwest Neonatal Critical Care Review
- Cheshire and Merseyside Provider Collaborative Blueprint

These programmes highlight interdependencies, configuration challenges, and sustainability risks, reinforcing the need for a coherent, system-led commissioning response.

4.1 Purpose of the Review

The review will:

- **Establish a system-wide baseline**
  - Variation in care, outcomes, and experience
  - Workforce and service capacity
  - Financial and operational sustainability
- **Identify risks and gaps**
  - Against national service specifications and best practice
  - Across safety, equity, and access
- **Develop system-level recommendations to**
  - Improve safety and outcomes
  - Reduce inequalities and unwarranted variation
  - Ensure clinical, operational, and financial sustainability
  - Strengthen workforce resilience and integration
- **Inform strategic commissioning decisions, including:**
  - Service configuration
  - Investment priorities
  - Future assurance and oversight arrangements

4.2 Scope of the Review

The review will cover all NHS-commissioned maternity services, including:

- Antenatal, intrapartum, and postnatal care
- Community, midwifery-led, and obstetric services
- Interfaces with neonatal and women's health services

It will assess:

- Clinical outcomes and safety
- Population health need and demographics
- Patient experience and lived experience
- Workforce capacity and sustainability
- Estate and infrastructure
- Digital capability and opportunity
- Commissioning and Financial Models

4.3 Strategic Commissioning Role of the ICB

This review is explicitly designed to support and strengthen the ICB's strategic commissioning function, as defined in the NHS strategic commissioning framework.

4.4 Core Strategic Commissioning Functions Delivered Through the Review

a) Population Health Leadership

- Analyse variation in outcomes and inequalities by:
  - Deprivation
  - Ethnicity
  - Geography
- Identify priority populations and unmet need

b) Setting Service Strategy and Configuration

- Define the future model of care for maternity services
- Assess:
  - Optimal service configuration
  - Clinical sustainability
  - Interdependencies with neonatal and women's health services

c) Commissioning for Outcomes and Equity

- Shift focus toward:
  - Safety outcomes
  - Experience and personalised care
  - Reduction in inequalities

d) System Design

- Consider the role and interaction of:
  - Acute providers

- Community services
- Neighbourhood and place-based delivery

e) Resource Allocation and Value

- Ensure financial sustainability of service models
- Align investment with:
  - Population need
  - Clinical risk
  - Strategic priorities

f) Enabling Integration

- Strengthen pathways across:
  - Maternity and neonatal services
  - Perinatal mental health
  - Public health and early years

4.5 Governance and Delivery Approach

The review will be delivered through an ICB-appointed Steering Group that will report to the ICB Executive Committee, with multi-disciplinary leadership including:

- Clinical leaders (midwifery, obstetrics, neonatology)
- Commissioners and quality leads
- Public health and safeguarding
- Lived experience representation

The approach will include:

- Data and evidence review
- Stakeholder and service user engagement
- Alignment with existing programmes
- Benchmarking against national and international best practice

4.6 Outputs and Deliverables

The review will produce:

- A formal system-wide report
- Evidence-based recommendations for future services
- Clear articulation of:
  - Risks and opportunities
  - Dependencies with neonatal and women's services
- Input to:
  - ICB decision-making
  - Potential Outline Business Case development

5. Recommendations

The Board is asked to:

1. **Endorse** the commencement of the maternity services review

2. **Endorse** the review as a core component of the ICB's strategic commissioning function.
3. **Agree** governance and reporting arrangements.
4. **Support** system-wide engagement and prioritisation of this work.

6 Next Steps

- Q3 26/27 Establish governance and mobilisation of steering group.
- Q3/4 26/27 The Steering Group will produce a detailed programme initiation document and programme plan
- 27/28 Undertake baseline assessment and engagement followed by development of recommendations and options
- Regular reporting on progress to Executive Committee

7 Appendices

Appendix One: Cheshire and Merseyside Maternity Review Terms of Reference

Appendix One:

Cheshire and Merseyside Maternity Review
Terms of Reference

1. Context

1.1 Maternity services across Cheshire and Merseyside are safety-critical services that play a fundamental role in population health, health inequalities, maternal and early years outcomes. C&M overall performance & outcomes have improved significantly over the past ten years however the system continues to experience pressures in ensuring consistency in outcomes, experience, access, workforce, workforce sustainability, estate and financial resilience despite interventions and oversight from the LMNS ICB over the past few years. These pressures are expected to be further impacted by the change in role and function of the ICB and the continued national spotlight on maternity and neonatal services in the light of national reviews such as Ockenden, Thirwell and Amos, mortality data from MBRRACE and the recommendations from the new national taskforce on Maternity Services.

1.2 The role of the ICBs has changed since the introduction of the model blueprint with more focus on strategic commissioning and the need for contract management of commissioned services to include:

- effective planning, improvement and quality assurance processes;
- identification of unwarranted variation and risk in different parts of the system and potential mitigations,
- supporting resource allocation to where it will have the greatest impact (allocative efficiency).

Ref: Section 3.1 NHS England » Strategic commissioning framework

1.3. In line with the ICB role change, there is a need to evaluate how this strategic operating model will function within the maternity context. It is proposed that a review of the current status of maternity services and any unwarranted variations is necessary to establish a baseline and consider further improvements.

1.4 This review is undertaken in a local context shaped by several major, inter-related transformation and assurance programmes, including:

- Shaping Care in Sefton, which highlighted the need for sustainable, high-quality models of care responsive to population need.
- The Women's services in Liverpool Case for Change and Options Appraisal, which identified configuration, co-dependency and safety risks within hospital-based women's services.

- The Northwest Neonatal Critical Care Review, led by NHS England Specialised Commissioning, which has direct clinical and operational interdependencies with maternity services.
- Review of services delivery in East Cheshire.

Cheshire and Merseyside Provider Collaborative Blueprint and system wide strategic plans including:

- Cheshire and Merseyside Population Health Improvement Plan.
- Cheshire and Merseyside 5 year Strategic Commissioning Plan .

1.5 The Maternity Review will provide a system-wide assessment and set of recommendations that are aligned with, and complementary to, these programmes and plans.

2. Purpose of the Review

2.1 The purpose of the Review is to:

i) establish a baseline of variations in care and identify risks in the system and mitigations.

ii) identifying gaps in nationally mandated service specifications and best practice guidance to inform commissioning intentions.

iii) develop evidence-based, system-level recommendations for the future shape of maternity services across Cheshire and Merseyside that:

- improve safety and outcomes for women and babies;
- reduce health inequalities and unwarranted variation;
- are clinically, operationally and financially sustainable;
- support a safe, skilled and resilient maternity and neonatal workforce;
- strengthen integration across maternity, neonatal and wider women's health services.

2.2 The Review will inform future ICB commissioning decisions, service configuration, investment priorities and assurance arrangements.

3. Objectives of the Review

The Review will seek to:

a) Safety and Quality

- Assess maternity safety, quality and outcomes across the system, identifying variation and systemic risk themes.
- Reflect learning from serious incidents, national maternity reviews and regulatory findings.

b) Equity, Access and Experience

- Examine inequalities in access, experience and outcomes, including variation related to deprivation, ethnicity, geography and vulnerability.

- Assess how effectively current models deliver genuine choice and personalised care.

c) Models of Care and Service Configuration

- Review current maternity models, including community, midwifery-led, obstetric and specialist provision and the alignment with national and regional best practice/service specifications.
- Consider alignment with conclusions and emerging directions from:
  - *Shaping Care in Sefton;*
  - *Liverpool Women's Services Case for Change and Options Appraisal;*
  - *Northwest Neonatal Critical Care Review.*

d) Workforce Sustainability

- Assess workforce capacity, capability, wellbeing and sustainability across midwifery, obstetrics, anaesthetics and neonatal services.
- Identify opportunities for system-wide workforce planning and stabilisation.

e) System Integration and Co-dependencies

- Examine interdependencies between maternity, neonatal critical care, perinatal mental health, safeguarding, public health and early years services.
- Ensure maternity recommendations support, and do not destabilise, neonatal critical care pathways.

f) Estate

- Assess adequacy of current estate for hospital-based care and opportunities for shift left to neighbourhood services with increased accessibility and provision at a local level.

g) Digital

- Review current digital systems and system readiness for the integration of the single patient record for maternity services.
- Explore opportunities for digital innovations and transformation to enhance service delivery, patient information and choice.

h) Financial Stability

- Review of historic contracting arrangements with Trusts, commissioned networks and services.
- Commissioning of maternity services based on population health, equity and clinical safety.

- Consider the sustainability of current models of care with recommendations for future models.

4. Scope of the Review

4.1 The Review will cover **all NHS-commissioned maternity services** across Cheshire and Merseyside, including:

- antenatal, intrapartum and postnatal care;
- community, midwifery-led and obstetric services;
- interfaces with neonatal and women's health services, including Gynaecology.

4.2 The Review will consider:

- clinical outcomes and safety intelligence;
- population need, demographics and epidemiology;
- patient experience and lived-experience insight;
- workforce, education and training arrangements;
- estate, capacity and service configuration;
- commissioning, finance and sustainability.

4.3 The Review will not replace or duplicate existing programmes but will draw explicitly on their findings and ensure system coherence across maternity, women's health and neonatal services.

5. Approach and Methodology

5.1 The Review will be informed by:

- Baseline evidence and data from current models of care and LMNS intelligence;
- national and international evidence, service specifications and best practice;
- insight from women, families, staff and partners;
- findings from related programme reviews and assurance activity.

5.2 Engagement will include clinicians, maternity and neonatal staff, commissioners, local authorities, voluntary and community sector partners, women and families and individuals with lived experience.

6. Governance and Leadership

6.1 The Review is commissioned by NHS Cheshire and Merseyside Integrated Care Board.

6.2 Oversight will be provided through an ICB-appointed Steering Group, reporting to the ICB, with representation from:

- clinical leadership (midwifery, obstetrics, neonatology, gynaecology);
- nursing and workforce leadership;
- commissioning and quality leads;
- public health and safeguarding;
- lived-experience representation;
- out of area independent expertise;
- other key stakeholders identified as appropriate (e.g. NHSE, NWAS, NWODN, North West Critical Care Network).

6.3 The review will report to the ICB Executive Committee in the first instance.

6.4 The Review will maintain active liaison with leaders of:

- Shaping Care in Sefton;
- Women's Services in Liverpool programme;
- NHS England Specialised Commissioning (Neonatal Critical Care);
- East Cheshire Services Review;
- C&M Provider Collaborative.

7. Outputs and Reporting

7.1 The Review will produce:

- a formal report setting out findings, risks and opportunities;
- system-level recommendations for future maternity services;
- identified dependencies with neonatal and women's health services;
- implementation considerations and next-phase requirements;

7.2 Outputs will inform ICB decision-making and progression to an Outline Business Case where appropriate.

8. Principles

The Review will be guided by the following principles:

- safety of women and babies is paramount;
- listening to women and families is central;
- equity and inclusion are fundamental;
- decisions are evidence-based and transparent;
- accountability is shared at system level.

9. Timescales

9.1 The Review will be undertaken during **2026-2027**, with milestones, reporting points and assurance routes agreed by the ICB.

Key Reference Documents

- *Shaping Care in Sefton* Review
- *Review of Women's Health and Maternity Services in Liverpool – Case for Change and Options Appraisal*
- *Northwest Neonatal Critical Care Review*, NHS England Specialised Commissioning
- *Model ICB Blueprint*
- NHS England » Strategic commissioning framework
- *Cheshire And Merseyside provider collaborative blueprint*
- *C&M 5 year strategic commissioning Intentions*
- *Cheshire and Merseyside Population Health Improvement plan*
- *National Women's Health Strategy 2022 and Refresh 2026*
- *NHS Framework for Neighbourhood Health*
- *2024 MBRRACE Report*
- Ockenden Report 2026 - www.ockendenmaternityreview.org.uk/wp-content/uploads/2026/06/ockenden-report-review-of-maternity-services-nottingham-university- hospitals-nhs-trust-web-accessible.pdf
- *Amos Maternity Review Final Report - www.matneoinv.org.uk/wp-content/uploads/2026/06/WEBSITE_NMNI-Final-Report-and-Recommendations.pdf*

Meeting of the Board of NHS Cheshire and Merseyside

26 November 2026

Draft Public Involvement Framework, and supporting Public Involvement Plan

Agenda Item No: ICB/11/26/26/10

Responsible Director: Ben Vinter, Executive Director Corporate Services & Governance

Report presented by: Jonathan Taylor, Head of Communications, Engagement & Public Affairs and Anna Kettle, Senior Communications, Engagement and Public Affairs Lead

REPORT SUMMARY SNAPSHOT

Required Information	Details			
Responsible Executive Director	Ben Vinter, Executive Director Corporate Services & Governance			
Report approval	**By**	Ben Vinter		
	Date	12.11.26		
Presented by	Jonathan Taylor, Head of Communication, Engagement and Public Affairs			
Ask of the Board	**Approval**		**Decision**	
	Endorsement	✓	**Ratification**	✓
	Receive assurance	✓	**Note**	
Route to Board – where has this report been discussed	Executive 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*				
Financial Implications*	**Yes**		**No**	✓
	If Yes:			
	Have the financial implications been reviewed by the Director of Finance			
	Has a budget been identified			
Legal Implications*	There are legal implications for any NHS organisation that fails to meet its involvement duties, and this framework and supporting plan outlines how we will ensure that we meet these duties as an ICB.			
Conflicts of Interest associated with this report	n/a			
Impact assessments undertaken*	**Equality**			
	Quality			
	Data			
	Sustainability			
Public or Clinical engagement undertaken	Extensive stakeholder engagement with system partners including NHS Trusts, local authorities, Healthwatch and the VCFSE sector has been undertaken as part of developing these documents.			

Draft Public Involvement Framework, and supporting Public Involvement Plan

1. Purpose of the Report

The purpose of this paper is to present the draft version of NHS Cheshire and Merseyside's Public Involvement Framework 2026 - 2028 (Appendix 1) for discussion, ahead of it being finalised, published on our website and adopted as the ICB's overall approach to involving people and communities in our work.

2. Executive Summary

NHS Cheshire and Merseyside's Communications, Engagement and Public Affairs Team has produced a revised and refreshed Public Involvement Framework which sets out the key principles, standards and ways of working that will help ensure the ICB delivers meaningful, inclusive and proportionate involvement activities and successfully meets its statutory duties.

The document should be read alongside a revised Public Involvement Plan 2026 – 2028 (Appendix 2), which provides further details about how we plan to deliver our own involvement work over the next two years and drive continuous improvement. A new Communications and Engagement Strategy (2026 – 2028) has also been produced (not for publication), which describes more about the team's overall functions and delivery.

A note on terminology

Throughout the framework we refer to the umbrella term 'involvement'. This is because involvement is the basis of our legal duties as an NHS organisation and can be used to describe a whole range of different ways in which we might involve people in our work – from formal consultations and engagement activity to ongoing involvement work.

3. Ask of the Board and Recommendations

3.1 The Board is asked to:

- Review and approve our proposed approach to involvement as described in the draft Public Involvement Framework 2026 – 2028 (Appendix 1)

- Provide any comments and feedback, so that it can be finalised, published on the ICB website (along with the Public Involvement Plan), and embedded as a best practice approach to involving people and communities in our work.

4. Reasons for Recommendation

4.1 Meeting our legal duties

As an Integrated Care Board (ICB), we have a legal duty to involve people in our work, as set out in the National Health Services Act (2006) and updated in the Health and Care Act (2022). These duties also apply to our NHS providers.

Although the Public Involvement Framework and supporting Public Involvement Plan clearly set out our duties to involve people, they do not specify how these responsibilities should be discharged. Specific approaches will be decided on a case for case basis, based on what is deemed proportionate and practicable.

In many instances, this will mean working in close partnership with our NHS providers and other key partners to jointly discharge these responsibilities – and this framework provides a strong basis of shared understanding to enable this to happen effectively.

4.2 Improving our effectiveness

While we recognise that as a strategic commissioner, we must effectively involve the people and communities that we serve, our commitment to involving people goes far beyond what we 'have' to do.

Meaningful involvement is something that we want to deliver because we recognise its power to help shape more effective solutions and services that better meet the needs of our population.

5. Background to document

5.1 Context

The first iteration of the Public Involvement Framework was published in July 2022 - at the establishment of NHS Cheshire and Merseyside as an Integrated Care Board. It was written following extensive engagement with a wide range of key partners, which included focused co-production sessions with the voluntary, community, faith and social enterprise (VCFSE) sector and Local Healthwatch.

It was published with the intention of being periodically reviewed and updated as/when required, in response to any major changes in organisational requirements or the wider health and care landscape. The publication of the Model ICB Blueprint (2025) which helped to clarify our role as a strategic commissioner and the subsequent development of a new Operating Model for NHS Cheshire and Merseyside provides a natural moment in time to undertake such a review.

5.2 Engagement process

The Communications, Engagement and Public Affairs Team has developed a refreshed and updated draft of the Public Involvement Framework and associated Public Involvement Plan during quarters one and two of 2026, with a focus on carrying over and further building on the strong foundations set out in the previous iterations published in 2022.

In recognition that a strong emphasis on collaboration is crucial to our effective delivery in the involvement space, a structured stakeholder engagement exercise was then undertaken, during which draft versions of each document were circulated to a wide range of key partners for feedback, including:

- NHS provider organisations
- Local authorities
- Healthwatch organisations
- Voluntary, Community, Faith, and Social Enterprise (VCFSE) organisations
- Community Voices (ICB public involvement mechanism).

Views were gathered via an online questionnaire, as well as meetings with key partners which enabled some more in-depth discussion about the approaches to take place. Feedback received has been used to shape a revised version of each of the documents, which are now being presented to the Board.

5.3 About the Public Involvement Framework

The framework describes our involvement model in detail and demonstrates how we intend to work. It details and explores:

- Ten key principles for involvement – national standards developed locally with key partners and reflecting a shared understanding of what high-quality, meaningful involvement should look like.
- Five main types of involvement – informing, engaging, consulting, co-designing and co-producing.
- Three main levels of involvement – system-wide, local level (either at local authority or combined authority level) and in our Neighbourhoods.
- Our main involvement infrastructure - including our methods of involving people, our key channels, our partnership approach, and governance structures.

At the end of the document, a series of case studies are also included to highlight previous examples of our involvement work, illustrate our involvement principles in action, and demonstrate what ‘good’ looks like.

5.4 Conclusion

In summary, our Public Involvement Framework establishes a clear, consistent, and accountable approach to involving people and communities in shaping health and care services across the system. We believe that this is important because it will lead to:

- Better decision-making.
- Reduced inequalities.
- Improved health outcomes.
- Better value for money.

Our ambition is to embed involvement into everything we do, ensuring that the voices of patients, carers, and communities are central to every part of our work as strategic commissioners – and this framework helps to articulate how we can turn that vision into a reality.

6. Next Steps

Subject to Board agreement, the Public Involvement Framework and Public Involvement Plan will be finalised, published on the ICB website, and importantly used to inform our approach involvement activity and further drive improvement.

7. Responsible person and contact details for more information

The authors of this report, as well as the Draft Public Involvement Framework and supporting Draft Public Involvement Plan to which it pertains, are:

Name & job title	**Contact**
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8. Appendices

Appendix 1: Draft Involvement Framework
Appendix 2: Draft Involvement Plan

NHS
Cheshire and Merseyside

Public Involvement Framework

Our approach to involving people and communities in Cheshire and Merseyside

2026 - 2028



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Introduction

About

NHS Cheshire and Merseyside Integrated Care Board (ICB) is committed to ensuring that the voices of people and communities are central to the planning, commissioning and delivery of health and care services.

As a statutory body, the ICB has a legal responsibility to involve people in decisions about services that affect them. This framework sets out how we will meet that duty consistently and meaningfully across the system and in our communities.

Building on strong partnerships with our staff, NHS providers, local authorities, wider system partners, and the voluntary, community, faith and social enterprise (VCFSE) sector, our focus is to embed involvement as a core part of decision-making rather than a standalone activity.

Purpose

This framework sets out how the ICB will continue to meet its statutory duty to involve people and communities in a meaningful and proportionate way across all aspects of its work.

This includes active involvement in:

- Planning services to ensure they are responsive to local needs and priorities.
- Shaping proposals for change, including service redesign and transformation.
- Informing decision-making about how services are delivered, ensuring transparency.
- Driving continuous service improvements informed by patient experience and voice.

Scope

How to use this document

This Public Involvement Framework is underpinned by a number of other supporting documents and strategies.

It should be read alongside our **Public Involvement Plan (2026 - 2028)** which provides further practical details about how we plan to deliver our involvement work over the next two years to drive continuous improvements.

Further organisational context and background is also provided in **NHS Cheshire and Merseyside's new Operating Model** which describes the organisation's new ways of working, key functions and priorities in more detail, as well as our **Joint Forward Plan (2026 - 2031)** which describes how we will work with wider system partners to meet our population's health needs.

This Involvement Framework aims to complement, rather than duplicate elements from each of these documents.

All of these documents are available on our website at: www.cheshireandmerseyside.nhs.uk and links are also provided at the end of this document.

A note on terminology

Terms such as 'consultation', 'engagement', 'participation', 'co-production' and 'involvement' are often used interchangeably. It is important that we are clear in our use of terminology.

Within this framework we will use 'involvement' as an umbrella term. This is because it's the basis of our legal duties as an NHS organisation, and because it can be used to describe a wide range of different activities that involve people in our work.

Context

NHS changes

There have been a number of significant changes made to the NHS landscape recently at a national level, which will inevitably shape and inform how we involve people in our work as an ICB moving forwards.

In May 2025, the publication of the **Model ICB Blueprint**, published by NHS England helped to clarify the core purpose of Integrated Care Boards as strategic commissioners and system convenors, affirming their key role in the future success of NHS systems.

It also initiated a process of organisational change which led to the development of a new Operating Model for NHS Cheshire and Merseyside.

In July 2025, the Government published the **10-Year Health Plan for England** which set the national direction of travel to reinvent the NHS via the development of a neighbourhood health model, with three radical shifts in focus including: hospital to community, analogue to digital, and sickness to prevention.

The **NHS Modernisation Bill** introduced to parliament in the King's Speech in May 2026, further progressed these intentions, and triggered the legal basis for large-scale NHS re-organisation, including cementing the process for abolishing NHS England and transferring its functions to the Department of Health and Social Care and Integrated Care Boards.

Importantly, these changes in NHS landscape underline the continued importance of involvement as a key enabler for success and reiterate the need for involvement to be seen as part of 'everyone's core business'.

All of these key changes at a national level will have an impact on our involvement work as an ICB, and how we continue to work with key partners and involve our patients and public in our work moving forwards.

Our legal duties

Involvement duties

As an Integrated Care Board (ICB), we have a legal duty to involve people in our work, as set out in the National Health Services Act (2006) and the Health and Care Act (2022), and so do our NHS providers. Further detail about these responsibilities are set out below.

In many cases, meeting our involvement duties will mean working with our providers and other key delivery partners to jointly discharge these responsibilities.

While national guidelines clearly outline what these responsibilities are, they do not specify how they should be discharged and this will therefore be decided on a case for case basis, according to what makes most practicable sense.

But our commitment to involving people goes beyond what we 'have' to do. Meaningful involvement is something that we strive to deliver because it can help shape more effective services that better meet the needs of our population.

Our core ambition is to effectively embed involvement into everything we do, ensuring that voices of partners, patients, carers and communities are central to our delivery and our decision-making.

- **NHS Act 2006 (Duty to Involve)**

This legislation places a legal duty on the ICB to involve patients, carers, and the public in the planning, development, and delivery of health services.

This includes consulting on service changes, gathering feedback, and ensuring that involvement activity is accessible, meaningful, and ongoing. The aim is to ensure that people's experiences and perspectives directly shape how services are designed and improved.

- **Health and Care Act 2022 (Triple Aim)**

The Triple Aim duty requires the ICB to consider the broader impact of its decisions across three key areas: improving population health and wellbeing, enhancing the quality and experience of care, and ensuring the sustainable and efficient use of resources.

This encourages a balanced and system-wide approach to decision-making, recognising the importance of long-term outcomes and prevention.

Equality duties

Alongside our statutory public involvement duties, the NHS is also expected to meet the Public Sector Equality Duty, and the Accessible Information Standard.

This means that all of our public involvement activity should be actively designed to support people with protected characteristics, social inclusion groups and those who experience health inequalities to be able to participate in a meaningful way – and often we will need to work in close partnership with providers and other key partners, particularly within the VCFSE sector, to achieve this.

- **Equality Act 2010 (Public Sector Equality Duty)**

Under this duty, the ICB must ensure that it actively considers equality and inclusion in all aspects of its work. This includes eliminating discrimination, advancing equality of opportunity, and fostering good relations between people with different protected characteristics.

This requires a proactive approach to identifying and addressing barriers that different groups may face in accessing services or participating in engagement.

- **Accessible Information Standard (AIS)**

This is a requirement for health and care organisations to identify, record, flag, share, and meet the communication and information needs of individuals with a disability, impairment, or sensory loss.

This ensures that information is provided in accessible formats (such as large print, braille, easy read, or via communication support) so that all individuals can access services and be fully involved in decisions about their care and in engagement activities.

Evidencing how we meet our duties

In addition to complying with these duties, we have to be able to clearly demonstrate and evidence how we have met our involvement responsibilities.

This includes evidencing:

- **Who was involved**: Identifying the individuals, communities and stakeholders who participated in involvement activities, with particular attention to the inclusion of diverse and under-represented groups.

- **How they were involved**: Describing the methods and approaches used to involve people, such as consultations, workshops, surveys, community outreach, or co-production activities, and ensuring these approaches were accessible and appropriate.

- **What was heard:** Capturing and analysing the feedback, insights, and lived experiences shared by participants, ensuring that a broad range of views and perspectives are represented.

- **How it influenced decisions**: Demonstrating how involvement outcomes have shaped decision-making, service design, or policy development, showing a clear link between what was heard and the actions taken.

Together, these requirements help us to ensure that involvement is not only carried out as a statutory obligation - but is fully embedded as a meaningful and integral part of our work.

Our involvement principles

We work in line with our ten involvement principles for working with people and communities, which are based on NHS England's but were further developed and refined for local use in partnership with the VCFSE sector as part of a comprehensive consultation process.

They reflect a shared understanding of what high-quality, meaningful involvement should look like – and adhering to them helps to ensure best practice.

For some recent examples of these principles in practice, please see the Case Studies in the Appendix (at the end of this document).

Our ten guiding principles for working with people and communities

1. Put the voices of people and communities at the centre of decision-making and governance at every level.

2. Start engagement early when developing plans and feed back to people and communities about how their engagement has influenced activities and decisions.

3. Understand our community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is having the desired effect.

4. Build relationships with excluded groups, especially those affected by inequalities.

5. Work with Healthwatch and the voluntary, community, faith and social enterprise (VCFSE) sector as key partners.

6. Provide clear and accessible public information about vision, plans and progress to build understanding and trust.

7. Use community development approaches that empower people and communities, making connections to social action.

8. Use co-production, insight and engagement to achieve accountable health and care services.

9. Co-produce and redesign services and tackle system priorities in partnership with people and communities.

10. Learn from what works and build on the assets of all health and care partners – networks, relationships and activity.

Our involvement objectives

Building on our ten involvement principles, the following involvement objectives will set the intention and direction for how we will focus our involvement work and prioritise resources for the next two years:

Ensure that involvement is embedded into our commissioning, governance and decision-making practices.	Provide a wide range of opportunities for people and communities to be involved in our work.	Ensure that a focus on hearing from under-represented voices underpins all of our involvement plans.
Design involvement routes which recognise different needs, preferences and styles, and aim to address any key barriers.	Prioritise hearing from people with relevant lived experience wherever possible.	Create inclusive mechanisms for involving people in shaping specific services and programmes of work, including major service change
Help ensure staff understand our involvement duties and proactively create opportunities to continuously involve people.	Focus on going to where people are, rather than expecting to reach them through corporate or organisational channels.	Use existing networks, forums, groups and community infrastructure to reach people where possible, rather than 'reinventing the wheel'.
Clearly demonstrate how people's feedback is used to improve services, influence decision making, and shape future planning.	Look for ways to share the insights we gather with key partners to help maximise the impact of involvement.	Collaborate with partners to co-deliver involvement activity, making the most of skills, expertise, opportunities, and share learning and best practice.

Our involvement model

Five main types of involvement

In its statutory guidance on involve people and communities, NHS England has set out five main ways to involve people and communities - each of which we will draw on at times as appropriate.

They include:

- **Informing**: Sharing information about proposed changes so people understand what they mean.
- **Engaging:** Listening to people to understand issues and discuss different ideas for change.
- **Consulting:** Formally asking for people's opinions on one or more ideas or options for service change.
- **Co-design:** Designing services by involving people in the process and incorporating their ideas.
- **Co-production:** An equal partnership where people with lived and learned experience work together to develop solutions, as part of an end-to-end process.

Source: **Working in partnership with people and communities: statutory guidance**

Choosing the right type of involvement.

The following chart provides a summary of key considerations:

Level	Description	When used	Examples	Methods
Inform	One-way information sharing	For low impact changes to services	Small changes to access such as opening hours or introducing a new booking system for appointments	Direct patient letter, text, email, website information, posters, notice boards
Engage	Listening and gathering views and experiences to help scope and inform plans	Used during service redesign, usually at an early stage to help scope plans, test a case for change or shape next steps	Redesigning care pathways or services	Questionnaires, focus groups, polls, listening sessions, public meetings
Consult	A formal two-way process to gather views and test draft proposals or options	Used when a change is likely to affect a significant number of people and/or have a high impact on key equality groups	When a proposed service change is deemed to be 'substantial' such as planning to permanently close or move a location of service	
Co-design	Gathering views and experiences of patients (usually with specific lived experience) to shape services	Used to enable service users or communities to help shape solutions	Developing a new service or pathway, or improving an existing one	Focus groups, workshops, patient lived experience panels
Co-production	Building an equal partnership where professionals and people with lived experience work together on a focused project	For involving patients in designing, planning, delivering and evaluating services	When wanting detailed patient voice to fully inform every step of a process	Ongoing involvement in a programme of work – end to end
Involvement	Enabling ongoing listening, dialogue and partnership	Used to help shape continuous service improvement	Long-term patient representation or involvement in a service	Patient advisory groups, reference groups, or patient participation groups / forums

Levels of involvement

Effective involvement requires a structured, multi-level approach. By flexibly working across different geographic footprints and/or demographic cross-sections of the population, we aim to ensure our involvement work is appropriately targeted, meaningful and impactful. This includes at each of the following levels:

- **System-wide or regional**

At a system level, involvement activity focuses on strategic priorities, large-scale transformation programmes, and significant service changes that affect the wider population. Sometimes our work crosses more than one area within Cheshire and Merseyside, and at times it can also involve working in partnership with other ICBs across the North-West based on patient flows.

This work typically includes the development of long-term plans, policies and integrated care strategies.

- **Local level (local authority or combined authority)**

Local involvement centres on how services are planned, redesigned, and delivered within specific local authority or combined local authority areas.

This work typically includes transformation of pathways of care, integration between organisations, and improvements to services, with the ability to collaborate with local stakeholders, delivery partners and local communities to ensure that services reflect local priorities and population needs.

- **Neighbourhood level**

Neighbourhoods bring together GP practices with wider primary care and community health teams, focused on serving populations of 30,000 to 50,000 people, with a strong emphasis on shifting care out of hospitals and into communities to deliver more proactive care and prevention of ill health.

This level of involvement typically supports very targeted preventative approaches, early intervention, and community-led solutions that are closely aligned to local needs.

Involvement infrastructure

There are four key mechanisms which underpin all of our involvement infrastructure, and we will describe the tools, channels and methods we use for each of them in more detail in the following section. These are:



Involvement methods

Method	Benefits
Surveys, questionnaires, quick polls and digital engagement	Provide flexible, cost-effective and scalable ways to gather feedback and reach a wide audience
Focus groups, 1:1 interviews and direct outreach	Enable deeper and more targeted exploration of specific issues, and particularly useful for hearing from underserved or seldom-heard groups
Lived experience panels	Provide structured, ongoing opportunity for a group of people with relevant lived experience to share their insights and perspectives
Community Voices (our involvement database and newsletter)	People can sign up to be kept updated on upcoming involvement opportunities – and be part of an ongoing, two-way conversation
Co-design workshops	Encourage open discussion, diverse input, and co-designed solutions – with participation from staff, key partners and patients
Patient advisory or reference groups (in–person/virtual)	Enable patients to work with services longer-term to support continuous improvement, usually with a specific area of focus
Healthwatch & VCFSE partnerships	Partnering with Healthwatch & VCFSE organisations and advocacy groups can help deliver targeted engagement to specific communities or groups
NHS patient participation groups (PPGs), networks and forums	Working with NHS partner such as NHS Trust patient experience teams and GP practice PPGs to gather views from already engaged individuals

Communication channels

Our communications and engagement team oversees a range of different channels for communicating with the public and other key stakeholders about different service change and improvement processes, including:



Face-to-face – one-to-one and group meetings, briefings (in person and virtual), drop-ins, workshops, events and exhibitions, as well as bi-monthly Board meetings, held in public, which include a public question time session at the start.



Media – local and national print and online newspapers, local and specialist magazines, local and national radio and TV, online-only media.



Print – letters, leaflets, newsletters, print advertisements, posters, questionnaires and forms, magazines, printed reports, and consultation and engagement materials.



Internal digital – our own staff intranet, internal webchat, discussion forums, all-staff/team email announcements and briefings, email bulletins and lock-screen messages.



External digital – our own website/s, digital engagement platform/s, partner/campaign/interest group websites, bulletins, blogs and vlogs



Social media – Our channels include X (formerly Twitter), Facebook, Instagram, YouTube and LinkedIn.



Marketing – banner-type promotion messages on our website, external digital advertising, print, radio, television and out-of-home advertising, promotion via third-party/partner channels and direct mail to homes.



Partner networks – engaging with partner channels, forums and networks to amplify messages as appropriate, often supported by a communications toolkit.

Working with our key partners

We recognise that effective, ongoing collaboration with a range of key partners is crucial to the successful delivery of our involvement activity. We already routinely partner with a wide range of stakeholders in our involvement planning and processes and will continue to build and strengthen these relationships. This following section provides more information on some of the main ways that we work with key system partners to deliver our involvement work:

NHS staff

We recognise that our NHS staff and volunteers are a key stakeholder – both as individuals with vast experience of the services they work in or alongside, and as members of our local population and users of services themselves.

It's important that we promote opportunities and encourage them to get involved and share these messages within their own social networks and communities and encourage other NHS partners to do the same.

Key internal channels we will use to communicate with and involve our staff include:

- Staff Hub (intranet)
- Staff internal newsletters (email)
- Staff briefing sessions (MS Teams)
- Staff networks

NHS system partners

A key part of our role as an ICB is in bringing together involvement functions across key system partners, including NHS provider trusts, primary care, local authorities (particularly public health), the VCFSE sector and other delivery partners.

This partnership approach enables the shared planning of involvement activity, reduces duplication, and promotes inclusive practices that help to reach diverse and underserved populations.

Through joint planning and delivery, coordinated communication activities, and convening forums that enable shared learning and good practice, we aim to support a cohesive 'whole system' approach to involvement. Some of the main ways we currently do this are via:

- Regular engagement with the existing provider collaborative communications network
- Developing and leading an involvement network
- Regular engagement with local authority partners via local communications collaboratives
- Sharing of best practice, involvement training and toolkits for primary care colleagues
- Leading programmes of shared working on specific service change programmes via communications and involvement delivery groups and wider reference groups.

Primary care teams

As most people's main touchpoint with NHS services, general practice also presents a great opportunity to engage with people, but the skills and capacity to support patient involvement within primary care can be limited.

We are already working with Patient Participation Groups (PPGs) at individual GP practices and Primary Care Networks (PCNs) to help harness patient insights, and we will be refreshing some of this work by offering further training and development sessions for these groups moving forwards.

In addition, we also want to look at how we can extend this work into other areas of primary care which the ICB has recently taken on commissioning responsibilities for, such as dental and pharmacy services.

Neighbourhoods

Although still a relatively new part of the health landscape, as local neighbourhood systems become more developed and mature across Cheshire and Merseyside, we want to work more closely to explore how we can best support and harness their potential to involve and empower people and communities in shaping local solutions.

The ways in which we can best achieve this will become more defined over the coming year but will begin through closer engagement with individual Neighbourhood Leads and closer working with some early pilot sites.

Political stakeholders

Engagement with local elected representatives and statutory bodies is another essential factor in ensuring transparency, accountability and alignment with local priorities. We aim to maintain strong relationships with political stakeholders and governance structures across the system to ensure that decision-making is informed by both community insight and democratic representation.

We will regularly brief, update and engage via each of the following routes:

- **Health and Wellbeing Boards**: Working in partnership to align priorities, share intelligence, and support the delivery of joint strategies that address the wider determinants of health.
- **Oversight and Scrutiny Committees:** Ensuring appropriate oversight and accountability by engaging with local authority scrutiny functions, particularly in relation to significant service changes and major decisions.
- **MPs and elected representatives:** Maintaining open and constructive relationships with Members of Parliament and local elected representatives to ensure they are informed, involved, and able to represent the views and concerns of their constituents, supported by regular email updates, as well as online and face to face briefing sessions.

Healthwatch organisations

We will continue to work closely with the nine local Healthwatch organisations across Cheshire and Merseyside to deliver our shared objectives and ensure that insight from local people informs service design, delivery, and improvement. As the role and function of local Healthwatch organisations continues to evolve, we will be working closely with local teams to ensure that we maximise every opportunity for further collaboration and the strengthening of patient voice within our commissioning work.

Voluntary, Community, Faith and Social Enterprise (VCFSE) sector

We recognise that the VCFSE sector plays a vital role in Cheshire and Merseyside, acting as key partners in engagement, insight gathering, and community connection. The VCSFE sector offers valuable expertise, trusted relationships, and deep understanding of local communities, particularly those who may be less likely to engage through traditional NHS routes, and working in close partnership as the potential to really strengthen outcomes for the patients and communities that we serve.

Our intention is to continue to strengthen our links with key sector leaders, as clearly reflected in our Memorandum of Understanding developed with the sector. We will achieve this working in continued close partnership with the Cheshire and Merseyside VCFSE Alliance which represents the sector across the region and is made up of three key forums: Cheshire and Merseyside VCFSE Health and Care Leaders Group, the Cheshire and Warrington Infrastructure Partnership (CWIP) and the VS6 Partnership in the Liverpool City region.

Our partnership approach

Some of the main ways that we typically partner with Healthwatch and VCFSE sector organisations in the delivery of involvement include:

- **Regular update meetings:** Holding regular update meetings with sector leaders where forthcoming work can be discussed, solutions to shared issues jointly owned, and opportunities for collaboration proactively explored.
- **Sharing information with communities**: Sharing information about involvement specific opportunities with local community organisations as relevant to help maximise our reach into communities and encourage participation.
- **Supporting specific workstream planning and delivery**: Inviting VCFSE representatives to be involved in the planning/delivery of projects, particularly when recognised as having knowledge or expertise which is well aligned.
- **Recruitment of patient voice representatives:** Asking key partners/networks to help s recruit individuals to participate in specific projects/activities, such as options development workshops, 1:1 interviews, focus groups or lived experience panels.
- **Commissioning where appropriate:** The ICB will at times directly commission VCFSE organisations to help deliver targeted engagement, insight and co-production/co-design activity, particularly to under-represented groups that we might otherwise struggle to engage with.

Involvement governance

How we work

Ensuring that involvement is embedded within governance structures and decision-making processes in our organisation is a key part of our work. Some of the main ways that we aim to do this include:

- **Implementing 'early engagement' scoping sessions** to help different teams ensure that involvement is factored in at an early stage in every programme or project.
- **Aligning involvement activity with Board and Committees processes** so that decisions are informed by lived experience and community perspectives wherever possible, alongside clinical, operational, and financial perspectives.
- **Ensuring that clear governance processes are agreed**, **understood** and fully described in our communications and engagement plans.
- **Ensuring that the VCFSE sector is fully embedded in our governance and decision-making processes** – working through both the ICB's organisational structures and the sector's own structures via our partnership with the Cheshire and Merseyside VCFSE Alliance.
- **Providing structured, organisation-wide systems and processes for planning, delivering and reporting** on our involvement activities.

Ensuring transparency in our decision making

Public Board Meetings

- **Meetings are held in public**: Enabling transparency, openness, and accountability in decision-making, and providing opportunities for members of the public to observe proceedings.
- **Community voice represented:** Ensuring community voices are represented in Public Board meeting via Board structures that include representation from Healthwatch and the VCFSE sector.
- **Live streaming is available**: Increasing accessibility by allowing people to join remotely and/or play back afterwards, helping to reach a wider and more diverse audience.
- **Clear and accessible processes are in place for public questions and statements:** Providing structured opportunities for members of the public to ask questions, submit statements, and contribute their views.
- **Access to board papers:** Offering easy access to meeting agendas, papers, and decisions made also supports openness and public scrutiny.

Equality, diversity and inclusion

Addressing inequalities

One of our key priorities is to build relationships with excluded groups, especially those who are affected by inequalities, so that we can understand and meet their needs better.

It is equally important that we listen to underserved groups such as people with specific health conditions, people experiencing homelessness, refugees and asylum seekers, or people living in deprivation and/or rural communities to make sure we reach a diverse range of people to give them the opportunity to share their views.

As part of achieving this, we will give extra focus to involving:

- **People with protected characteristics:** such as young people, older people, LGBTQI+ individuals, people with disabilities, as well as people of different colour, nationality, ethnic origin or religious belief.
- **People from under-served communities:** who are traditionally under-represented or face barriers to accessing services, including people experiencing socio-economic disadvantage, minority ethnic groups, individuals with disabilities, unpaid carers, and those who may be socially isolated.

To help us do this effectively, we will work closely with organisational Equality, Diversity and Inclusion (EDI) leads to ensure that the following documents inform all of our involvement work:

- **Equality Impact Assessments (EIAs)**
- **Quality Impact Assessments (QIAs)**

These are key documents used help us understand which groups may need to be disproportionately impacted and may therefore need additional support from a programme of work to inform all of our involvement approach**.**

Digital inclusion

Like many organisations, our core communications channels are largely online. Although we will always take a ‘digital first’ approach as a cost-effective and environmental way to reach the majority of people, **we will always provide alternative routes** to include those who are not digitally engaged, particularly during specific involvement activities.

This typically includes providing a telephone number, paper-based versions of surveys and questionnaires and information materials, and face to face public meetings and events.

At times, we’ll also work with key partners, either via in-house health teams or advocates in the voluntary and community sector, to help us engage with harder to reach groups in a more targeted or focused way.

Adapting methods to remove barriers to involvement

As part of our commitment to the inclusion of diverse groups and those experiencing inequalities, we will always aim to ensure that our involvement methods are flexible and inclusive, addressing barriers such as language, literacy, digital exclusion, transport, and cultural differences, by drawing on a wide range of different channels and methods.

This typically includes:

- Providing paper-based alternatives to digital materials and questionnaires for those who are digitally excluded.
- Providing a blend of digital, print and in-person/face to face channels to suit a range of preferences and needs.
- Offering Easy Read, Large Print and British Sign Language (BSL) translations as standard.
- Signposting people to a single (telephone / email) point of contact for requesting other languages/formats as required.
- Partnering with local community and voluntary sector organisations as trusted intermediaries to help us deliver targeted activity and maximise our reach into lesser heard communities.
- Building equality monitoring questions into all of our involvement activities to help us monitor who we are reaching.
- Using real-time data monitoring to help identify and address any gaps in our reach, and under-taking any course correction and adjustments as required.
- Working with our EDI leads to disaggregate feedback and data collected to help us identify any communities or groups disproportionately affected by an issue or service change, to help us mitigate this risk.

Service change

A tailored approach

A significant element of our involvement work will support the development of health service changes, such as service development, improvements, closures, relocations, and wider system reconfiguration.

It's crucial that we have clear arrangements in place for involving people from the outset of each service improvement, change or transformation programme – which builds on our involvement model.

It's important to understand that our approach to supporting service change processes is not a 'one size fits all' model – our planning is tailored according to the type of services we are looking at changing, the scale of potential impact, and the needs of the people and communities affected by a proposed change.

For example, while some service change processes would require mass marketing to reach a wide audience, some service changes will only affect a much more targeted group of people.

Each service change project or programme will therefore have a bespoke communications and engagement plan tailored to requirements, and detailing how we plan to involve people throughout the project lifecycle.

It's also important that involvement is not viewed as something that only happens in response to these high-profile changes; but as an ongoing and continuous process, embedded in everyday planning, decision-making, and service improvement.

This ensures that people, communities, and stakeholders have consistent opportunities to shape services, build trust, and influence outcomes long before formal consultation on major service change is required.

Involvement culture

Embedding involvement

Although we have a communications, engagement and public affairs team with specific responsibilities for involvement, we aim to ensure that everyone who works for us sees involvement as part of our 'core business'.

We are committed to creating an environment where involvement is valued, embedded, and effectively resourced across all levels of the local health and care system.

As part of this, we will:

- Work with individual commissioners and teams to embed involvement activity in the commissioning cycle, supported by training and additional resources where needed.
- Encourage shared responsibility for involvement across staff, partners and stakeholders, ensuring that it is owned collectively and not siloed, or limited to specific teams or functions.
- Build strong community relationships, maintaining trusted, long-term relationships with communities, recognising the importance of consistency, transparency, and responsiveness, and providing the mechanisms involvement mechanism to make this happen.

Resources

Delivering high-quality, meaningful involvement requires a strong organisational culture, a skilled and supported workforce, and the appropriate allocation of resources.

We recognise that ensuring our involvement activity is appropriately supported and capable of delivering meaningful outcomes requires adequate resourcing, working to NHS England's latest policy and guidelines.

This includes:

- Funding: Allocating appropriate resources to support activities, including commissioning external partners and VCFSE organisations with specialist skills where required.
- Participant reimbursement: Recognising and valuing people's time, contribution and expertise by offering appropriate reimbursement, payment and support, removing financial barriers to participation
- Training and tools: Equipping staff and partners with the training, skills, knowledge, and practical tools required to deliver effective involvement.

Further detail about this is set out in: NHS England's policy on working in partnership with people and communities (2021).

Analysis and reporting

Ensuring openness and transparency

Making sure that we ‘close the loop’ on our involvement activity, by providing timely feedback to those who took part, is important in ensuring that involvement is a genuine, two-way process.

We do this by:

- publishing findings reports detailing any feedback we have received in an easy to read, accessible format via our website.
- proactively sharing these insights with a wide range of stakeholders through stakeholder briefings, and media briefings.
- sharing findings with local scrutiny committees, MPs and elected members/councillors as part of our commitment to continued engagement with these groups.
- taking these reports through our public Board for further discussion and scrutiny.

Monitoring and evaluation

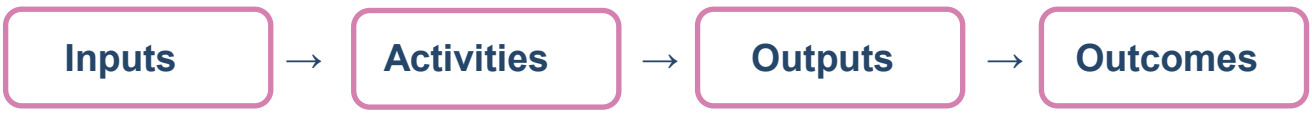
Our evaluation model

Understanding the effectiveness of our involvement plans helps us to improve future activity by providing insight into the techniques and methods that allow us to reach our target audiences.

We aim to build clear feedback measures into all of our involvement plans and activities. For example, we will often ask people to tell us where they heard about a particular engagement opportunity so that we can consider this in future planning.

Forums such as specific communications and engagement delivery groups or reference groups also allow us to discuss our involvement effectiveness and embed continuous learning and improvement into all of our involvement work.

We use the following model to help us ensure a consistent approach:



How does this look in practice?

This approach enables the ICB to track the resources invested (inputs), the engagement undertaken (activities), the immediate results (outputs), and the longer-term changes achieved (outcomes).

In practice, this means that we will measure:

- **Breadth of reach:** Assessing who is engaging, including the overall number of participants - *it is proportionate?*
- **Diversity of reach:** Assessing the diversity of those involved, with a particular focus on inclusion of underserved and underrepresented groups – *is it representative?*
- **Quality of engagement:** Evaluating how well activities are delivered, including the extent to which they are accessible, inclusive, and meaningful for participants – *is it effective?*
- **Impact on decisions:** Demonstrating how engagement has influenced decision-making, service design, and policy development – *is it meaningful?*
- **Improvement in outcomes:** Assessing the longer-term impact of engagement on services and population health outcomes, including whether changes have led to improvement – *is it impactful?*

Key evaluation mechanisms

An involvement process offers a range of potential metrics for evaluation which will be useful information to help evidence the breadth of reach we have achieved, as well as the effectiveness of different activities undertaken.

Some of the key metrics we typically use are described below:

- Numbers of questionnaires completed – is it proportionate for the changes being proposed?
- Geographic and demographic breakdown of responses received – have we heard from a wide range of voices?
- Number of calls/emails requesting clarifications – was the information provided clear enough?
- Requests for accessible formats – are we being inclusive, and have we provided information in the right formats for our communities?
- Number of sign-ups to Lived Experience Panels or Reference Groups – how engaged are people in the issues being discussed?
- Numbers of people attending engagement sessions – who do our in-person and online events capture, and are they enabling us to hear from a range of different voices?
- Numbers of people taking part in focus groups or 1:1 interviews – have we sufficiently heard from those most directly affected by a proposal?
- Number of community/voluntary sector partners taking up offer of an event, and/or sharing information with their own networks – how far are we extending reach through key partnerships?
- Equalities reach – have we heard from the priority groups outlined within the Equalities Impact Assessment (EIA) report?
- Amount of media coverage generated – have we created enough general public awareness about an involvement process?
- Website page views and click throughs – where is online interest and traffic coming from?
- Social media impressions and engagement levels – is our marketing and communication activity cutting through the noise and encouraging participation?

Conclusion

In summary

In summary, this framework establishes a clear, consistent, and accountable approach to involving people and communities in shaping health and care services across the system. Our ambition is to embed involvement in everything we do, ensuring that the voices of patients, carers, and communities are central to decision-making.

We believe that this is important because it will lead to:

- **Better decisions:** Informed by lived experience, insight and diverse perspectives.
- **Reduced inequalities:** Achieved by including and prioritising under-represented groups.
- **Improved health outcomes:** Supported by designing solutions *with* rather than *for* people, which leads to more responsive, effective and person-centred services.
- **Better value for money:** By involving people, we're more likely to get it right first time.

Tell us what you think

As part of our collaborative approach to involvement, we will be sharing this framework with a range of involvement partners for feedback and will continue to refine and revise elements of this work as we move forwards.

We are always keen to hear what people think about our involvement work, and how we can improve what we do.

You can provide your views and input into our involvement work at any time by emailing: engagement@cheshireandmerseyside.nhs.uk

Appendix: Principles in Practice

About these case studies

As an appendix, we have included a series of case studies as examples of our recent involvement work to help demonstrate how our involvement principles work in practice.

These case studies highlight a range of different levels and types of involvement processes around NHS service changes that we are frequently required to support, including:

- **Public consultations on major service change**
  > Example: Hyper-acute stroke services in North Mersey (2022)

- **Pre-consultation engagement on a case for change**
  > Example: Hospital gynaecology & maternity services in Liverpool (2024)
  > Example: Neonatal critical care services in the North West (2026)

- **Public consultation on changes to access for a specialist service**
  > Example: Fertility treatment policies in Cheshire and Merseyside (2025)

- **Public engagement process for a service relocation**
  > Example: A GP practice relocation in Cheshire (2026)

- **Public engagement process on minor changes to clinical policies**
  > Example: Harmonisation of 25 clinical policies for minor treatments and procedures (2025)

Case Study: Hyper-acute stroke services in North Mersey (2022)

Type of involvement: Public consultation on changes to access

Context: We delivered a 12-week public consultation on a proposal for a new Comprehensive Stroke Centre at Aintree University Hospital, bringing together the hyper-acute care provided at Aintree, the Royal Liverpool and Southport hospitals.

Principles in action

> Start engagement early, when still developing plans
> Focus on understanding your community's needs, experiences and aspirations
> Provide clear and accessible information
> Engage with staff first
> Involve those with lived experience
> Build relationships with excluded or marginalised groups

What we did

- Delivered a 12-week consultation to explain the case for change, share the options considered and seek views on the preferred proposal for a Comprehensive Stroke Centre based at Aintree University Hospital (alongside The Walton Centre).
- Coordinated planning and delivery, working in close partnership with the three provider Trusts, and commissioning colleagues in Knowsley, Liverpool, South Sefton, Southport & Formby, and West Lancashire.
- Supported a staff engagement process (delivered by trust colleagues) ahead of the public consultation phase, specifically to hear from staff groups who were directly affected by the proposals.
- Invited people from across the North Mersey footprint to share their views via a questionnaire (paper versions were also available).
- Utilised a range of feedback methods/channels to help meet the wide range of communication needs and access requirements that stroke survivors have – including online, print, face to face, phone, email, and also provided information in alternative formats.
- Worked with the hospital to directly contact patients and former patients of the service to invite them to share their views.
- Partnered with the Stroke Association to deliver a series of engagement events and focus group sessions to hear directly from stroke survivors and their families and carers.
- The Stroke Association were also fully embedded in the governance process around improving stroke care across the region to help ensure that patient voice was central to decision-making.
- Information was also shared with a range of local health and care partners, Healthwatch organisations, and VCFSE organisations as other key routes for engaging those with lived experience of stroke services in the region.

Hyper-acute stroke services in North Mersey (continued)

Impact

More than 600 people took part in the consultation, including a high number of stroke survivors and those with lived experience of using stroke services.

Most stroke patients and carers who responded supported bringing hyper-acute stroke services together in one location, recognising the benefits of more specialist expertise being available in a single centre. Feedback also highlighted concerns about hospital admission arrangements and the availability and quality of post-stroke support

The North Mersey Stroke Service was subsequently established at Aintree University Hospital in 2023, bringing together care previously provided across Aintree, the Royal Liverpool and Southport hospitals. It has since ranked among the top three stroke units in England in national audits and has received an NHS Parliamentary Award.

Case Study: Hospital gynaecology and maternity services in Liverpool (2024)

Type of involvement: Pre-consultation engagement on a Case for Change

Context: We worked with key partners to deliver a six-week pre-consultation engagement on a Case for Change for improving gynaecology and maternity services in Liverpool.

Principles in action

> Start engagement early, when still developing plans
> Focus on understanding your community's needs, experiences and aspirations.
> Build relationships with excluded groups
> Provide clear and accessible information
> Engage with staff first
> Involve those with lived experience
> Work with Healthwatch and VCFSE sector as key partners

What we did

- Set up a Communications Delivery Group to support engagement planning and delivery, with representation from the ICB, affected hospital Trusts and Healthwatch.
- Developed a public summary explaining the Case for Change and created a bespoke website to act as a single NHS information source. Alternative formats were also available including: a printed version, Easy Read, BSL, and other languages.
- Collected views via an online questionnaire (paper versions also available), six public engagement events held in Knowsley, Sefton and Liverpool, and one staff session.
- Partnered with Liverpool CVS to commission six local community organisations to deliver targeted engagement to diverse communities – including women affected by homelessness, addiction, mental health issues and non-English speakers.
- Formed a Lived Experience Panel to help ensure patient experience was central to every stage of the programme – members took part in engagement planning, tested public information materials, shared their own experiences, and took part in options development workshops.
- Undertook extensive stakeholder mapping and sent out regular stakeholder briefings to ensure a wide range of stakeholders were kept updated.
- Promoted the engagement via signage and marketing materials on hospital sites, media releases which resulted in 'across the board' coverage in local press, radio, online and regional TV news, presenting at local community organisations, and social media posts which generated 5,718 'click-throughs' to the programme website.
- Issued a communications toolkit to help partner organisations promote the engagement via their own internal and external communications channels.
- Set up a Virtual Reference Group to enable people to stay updated.

Hospital gynaecology and maternity services in Liverpool (continued)

Impact

Over 1100 people actively participated in the engagement process, with responses coming from a broad cross-section of the community.

This included 913 people who completed the online questionnaire, including a high percentage of harder to reach audiences who were supported to take part by Liverpool CVS and their community partner organisations.

In addition, 74 people commented via social media, 13 by email and 1 by letter. 71 people also attended a public engagement event, 26 people were part of the Lived Experience Panel, and 27 staff members took part in a staff engagement session.

Insight gathered indicated broad support for the case for change, with 82% of all respondents in agreement about the need to make changes to the way gynaecology and maternity service were arranged.

The findings from the engagement were drawn into a summary report, which was published and shared with key stakeholders, and subsequently used to help inform some options development workshops which took place in summer/autumn 2025.

Case Study: Neonatal Critical Care Service in the North-West (2026)

Type of involvement: Pre-consultation engagement on a Case for Change

Context: We worked with the North West Safe and Sustainable Specialised Health Services for Babies & Children programme team to deliver an engagement process to hear from staff and parents/carers on their experiences of care and views on a refreshed Case for Change on improving neonatal critical care across the region.

Principles in action

> Start engagement early, when still developing plans
> Focus on understanding your community's needs, experiences and aspirations
> Provide clear and accessible information
> Engage with staff first
> Involve those with lived experience
> Work with VCFSE sector as key partners

What we did

- Set up a Communications Delivery Group to support engagement planning and delivery, with representation from the region's three ICBs, the programme team, NHSE North West, and service representatives
- Developed a public summary document explaining the Case for Change. Alternative formats were also made available.
- Collected staff views on the Case for Change via an online questionnaire, and through nine virtual staff engagement sessions delivered for neonatal teams across 22 units.
- Ran three focus group sessions (one in each ICB area) focused on hearing from parents/carers with lived experience of using neonatal services about their experiences of care (covering what worked well, and what could be better for babies and families).
- Offered one-to-one interviews to support participation for parents/carers who either couldn't attend one of the focus groups, preferred to speak confidentially rather than in a group setting, or required additional support to participate.
- Worked with the Neonatal Operational Development Network, existing Patient Advisory Groups, local Maternity and Neonatal Voice Partnerships (MNVPs), and a neonatal charity based in Greater Manchester (Spoons) to support recruitment, ensuring we heard from a wide range of families.
- Used a trauma-informed approach to deliver all of the parent/carer focus group sessions and one-to-one interviews.
- Undertook extensive stakeholder mapping for the programme and issued a series of briefings to keep a wide range of stakeholders updated on how the process progressed.

Neonatal Critical Care Service in the North West (continued)

Impact

In the staff engagement phase, a total of 115 members of NHS staff who work in neonatal critical care services participated in the nine virtual events, and 184 staff survey responses were received.

Staff overwhelmingly agreed that changes were needed in the region's neonatal services, although there was a small minority who expressed some concerns about what this might mean for the future of different units.

A total of 40 parents and carers with lived experience of using neonatal units in the region also took part in the engagement, including 29 via focus group sessions, and 11 via a one-to-one interviews.

Again, feedback was broadly supportive of the need to improve services for babies and families. Parents said they were comfortable with key principles described in the case for change such as having fewer units that were larger and more specialised if it meant better outcomes for babies but also expressed a range of caveats around this.

Feedback was summarised in a findings report, published and shared with participants and wider stakeholders, and will be considered as part of the options development process, alongside financial, estates and clinical evidence.

Case Study: Fertility services in Cheshire and Merseyside (2025)

Type of involvement: Public consultation on changes to access

Context: We delivered a public consultation on proposed changes to local fertility treatment policies to remove inequitable variation in access to IVF treatment and ensure local practice was in line with national guidance. Some changes were also considered for financial reasons.

Principles in action

> Start engagement early, when still developing plans
> Focus on understanding your community's needs, experiences and aspirations
> Provide clear and accessible information
> Engage with staff first
> Involve those with lived experience
> Build relationships with excluded or marginalised groups

What we did

- Launched a six-week consultation focused on hearing from patients and staff, collecting feedback via both an online and paper-based questionnaire, working in close partnership with the provider (Liverpool Women's Hospital and The Hewitt Centre).
- Ensured early engagement with those working in the service through staff briefing sessions, and by sharing information with staff via team meetings and the staff intranet.
- Sent information about the consultation and how to take part to all current and previous service users registered on the service's patient portal via email/letter, and texts.
- Signposted patients to take part with posters and leaflets exhibited in patient waiting areas in the hospital, as well on the service's website.
- Worked closely with the Trust's equality and diversity leads to help maximise engagement among patients and staff from diverse communities.
- Shared information with a range of local health partners including Healthwatch, the VCFSE sector and local fertility networks as other key routes for engaging those with lived experience of using fertility services.

Impact

More than 2,100 people shared their views, which was a high response rate that indicated a good awareness level among those most directly impacted by the proposed changes.

Feedback was analysed and set out in a report which was presented to the Board, alongside an equalities impact assessment (EIA) detailing the impact of the change for different groups for full consideration, ahead of a final decision being made.

Case Study: Proposed GP practice relocation in Cheshire (2026)

Type of involvement: Public engagement process on a relocation of care

Context: We supported a GP practice to engage with their patients while considering a relocation to new, more modern and spacious premises as they recognised that any change to access could create challenges for some patients, particularly those who walked/ relied on public transport to attend or had additional accessibility or communication needs.

Principles in action

> Start engagement early, when still developing plans
> Focus on understanding your community's needs, experiences and aspirations
> Provide clear and accessible information
> Build relationships with excluded groups
> Work with VCFSE sector as key partners
> Involve service users in engagement and decision-making processes

What we did

- Provided strategic advice and support to help the practice plan, assure and deliver a phased engagement process to gather patient feedback on the potential relocation.
- The practice invited all 8,400 registered patients to take part in an initial feedback survey, with information sent by email, text or post (according to patients' usual communication arrangements). Patients could respond online or via a paper version.
- Recognising that its usual communications routes might not reach everyone, the practice also partnered with local community organisations supporting people seeking asylum and people who do not speak English as their first language. This helped engage more patients from diverse communities and has created strong community links that will continue beyond the process.
- The practice also held four drop-in sessions at the proposed new site, attended by 20 patients which included a tour of the facilities and a chance to ask questions directly, with practice staff and Patient Participation Group (PPG) representatives present.
- The proposed relocation was also regularly discussed with the PPG, giving patient representatives an ongoing role in considering the proposal and issues raised through the process.
- The practice then delivered a second phase of engagement, in which all patients received additional information addressing questions and concerns raised during the initial engagement, and were invited to provide further feedback.
- Questions and concerns were responded to individually, with further discussion offered to patients where required.

Case Study: Proposed GP practice relocation in Cheshire (continued)

Impact

The patient survey received a total of 678 patient responses, including 126 paper responses. More than two thirds of respondents supported or strongly supported the proposal, but feedback also identified a number of patient concerns about travel/public transport, accessibility, continuity of care, and maintaining non-digital ways of contacting the practice.

During the second phase of engagement, a further 48 pieces of patient feedback were received. Twelve raised further questions about travel and transport, three asked about appointment availability, and 33 contacted the practice to express their support.

The engagement process provided the practice with a detailed understanding of both overall patient views, and the potential impact of the relocation on particular groups.

The feedback gathered is now being used to develop practical measures to support patients, particularly around access and travel/transport requirements, should the relocation go ahead.

The approach demonstrates the value of seeing engagement as an ongoing conversation rather than a single survey. By combining whole-population engagement with accessible response methods, targeted community outreach, active PPG involvement, site visits and direct responses to concerns, the practice was able to use patient feedback to identify potential barriers to access and help shape how changes can be implemented in a way that effectively support their patients.

Case Study: Harmonisation of 25 clinical policies for minor treatments and procedures across Cheshire and Merseyside (2025)

Type of involvement: Public engagement process on changes to clinical policies

Context: We undertook a review of 25 local clinical policies which were inherited from Clinical Commissioning Groups (CCGs) to ensure consistent and equitable access to treatments and procedures for patients, regardless of where they lived in Cheshire and Merseyside.

Principles in action

> Start engagement early, when still developing plans
> Focus on understanding your community's needs, experiences and aspirations
> Provide clear and accessible information
> Involve those with lived experience
> Build relationships with excluded groups
> Work with Healthwatch and VCFSE sector as key partners

What we did

- Invited patients, residents, health professionals, local community groups and charities to comment on proposed changes to 25 clinical policies and identify any potential impacts on patients, families and carers.
- Provided information about the proposals on the NHS Cheshire and Merseyside website, alongside an online questionnaire designed so people could respond only to the policies of relevance/interest to them. Paper copies and alternative languages and formats were also made available on request.
- Offered a dedicated phone line and email address as alternative ways for people to give feedback, ask questions and request further support.
- Worked with key partner organisations, including NHS organisations, GP practices, local authorities, Healthwatch and VCFSE groups to help promote the engagement, supported by a communications toolkit.
- Identified relevant condition-specific patient groups/networks, community groups and charities and contacted them directly to invite them to participate and share views on behalf of their communities.
- Promoted the engagement via wider channels including local media, social media, and stakeholder briefing and communications.
- Used equality monitoring questions to help us understand who had responded and identify whether views or impacts differed between communities or groups, supporting consideration of any potential adjustments or mitigations required.

Case Study: Policy harmonisation of 25 clinical policies for minor treatments and procedures across Cheshire and Merseyside (continued)

Impact

In total, 116 people responded to the online questionnaire, with 100 people indicating an interest in commenting on one or more of the 25 draft policies. The number of responses to individual policies varied considerably, so the findings were treated proportionately.

Feedback identified a range of views about the proposed changes, including areas of support and concerns about potential impacts on access to treatment, and impacts for particular patient groups. Respondents also raised questions about clinical criteria and processes.

Where comments related to clinical matters, or fell outside the direct scope of the engagement, relevant feedback was passed to the NHS Cheshire and Merseyside programme team for consideration outside of this process.

The findings were summarised in an engagement report, published and shared with key stakeholders, and considered via governance and decision-making processes, with the feedback used to inform the final versions of the 25 policies.

Useful links

National

- 10-Year Health Plan for England: fit for the future
- NHS Modernisation Bill (2026)
- Model ICB Blueprint
- Neighbourhood Health Framework
- NHS England's Statement on Information on Health Inequalities
- Core20PLUS5 for adults and for children and young people
- Working in Partnership with People and Communities
- Major service change: An interactive handbook (2023)
- Accessible Information Standard and related implementation guidance

Local

- Clinical and Strategic Commissioning Plan 2026-31
- Population Health Improvement Plan 2026-31
- Public Involvement Plan (2026-2028)
- Memorandum of Understanding with VCSFE sector

NHS
Cheshire and Merseyside

Our Involvement Plan 2026 - 2028

How we will involve people and communities in Cheshire and Merseyside



Contents

1. About this plan
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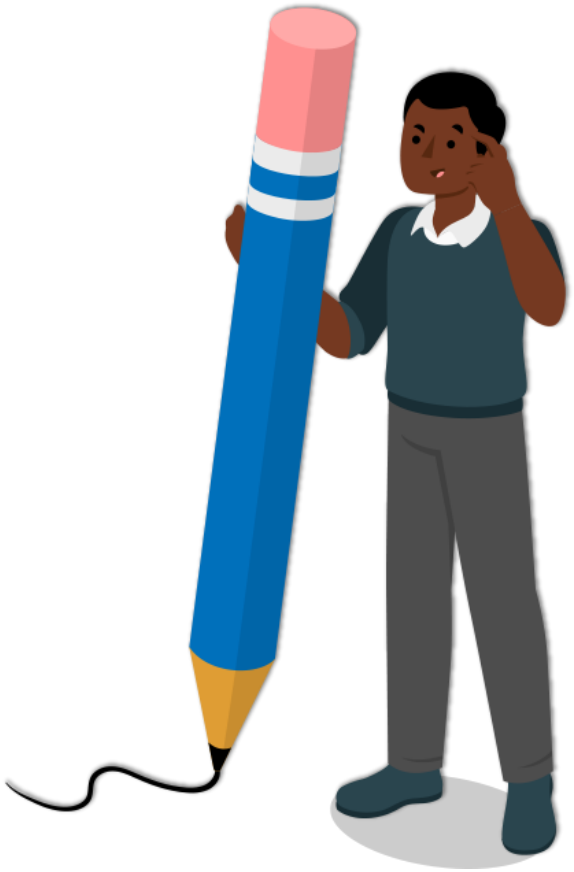
3. Terminology
4. Our ten key principles
5. Our involvement objectives
6. Involvement infrastructure:
1. Service change
2. Feedback and reporting
3. Monitoring and evaluation
4. Key actions
5. Tell us what you think



1. About this plan

The main focus of this plan is to explain how we will partner with people and communities to involve them in our work. It summarises:

- our overall approach to involvement **(how we work)**
- key actions we will be taking forward to enhance our approach **(how we can improve).**

This is a high-level plan which sets the direction for our work to improve our involvement offer. Individual action plans will be developed for each area of work outlined.

This two-year plan is a refresh of our previous involvement plan (2024-26), and the intention is that it will continue to be reviewed, refreshed and updated regularly, in conversation with key partners.

This plan should be read alongside our **Public Involvement Framework (2026 – 28)** which outlines our broad approach to all involvement work that we undertake as an ICB because this plan builds on that document.



2. Duties and aims

As an Integrated Care Board (ICB), we have a legal duty to involve people in our work, as set out in the National Health Services Act (2006) and the Health and Care Act (2022), and so do our NHS providers.

In many cases, this means working together as commissioners, providers and other key delivery partners to jointly discharge these responsibilities as it makes most practicable sense.

Our commitment to involving people goes far beyond what we 'have' to do.

We recognise that in order to help reduce inequalities and improve health and care outcomes for our population, we must effectively involve the people and communities that we serve.

However, meaningful involvement is something that we strive to deliver continually because it helps us to develop and shape more effective services that better meet the needs of our population.



3. Terminology

Terms like engagement, involvement, participation and consultation are often used in relation to this area of work, sometimes interchangeably. However, in its **statutory guidance**, NHS England sets out five distinct ways of working to involve people and communities as follows:

1. **Inform**
   Sharing information about proposed changes so people understand what they mean.
2. **Consult**
   Formally asking for people's opinions on one or more ideas or options.
3. **Engage**
   Listening to people to understand issues and discuss different ideas for change.
4. **Co-design**
   Designing services by involving people in the process and incorporating their ideas.
5. **Co-production**
   An equal partnership where people with lived and learnt experience work together to develop solutions, as part of an end-to-end process.



In this plan, we will use the umbrella term involvement.

This is because it's the basis of our legal duties as an NHS organisation, and also because it can be used to describe a wide range of different activities.

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Part 1: Our involvement approach (how we work)



4. Ten key principles

Our **ten key principles for working with people and communities** were developed using NHS England's statutory guidance as a starting point, working in close partnership with the VCFSE sector in Cheshire and Merseyside to refine them for local use through a comprehensive consultation process.

They reflect a shared understanding of what high-quality, meaningful involvement should look like – and adhering to them will help to ensure that our involvement work represents best practice.



4. Our ten key principles

1. Put the voices of people and communities at the centre of decision-making and governance at every level of the Integrated Care System (ICS).

2. Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.

3. Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.

4. Build relationships with excluded groups, especially those affected by inequalities.

5. Work with Healthwatch and the VCFSE (voluntary, community faith and social enterprise) sector as key partners.



6. Provide clear and accessible information about vision, plans and progress, to build understanding and trust.

7. Use community development approaches that empower people and communities, making connections to social action.

8. Use co-production, insight and engagement to achieve accountable health and care services.

9. Co-produce and redesign services and tackle system priorities in partnership with people and communities.

10. Learn from what works and build on the assets of all ICS partners - networks, relationships, activity in local places.

5. Our involvement objectives

In 2026-8, the following revised delivery objectives will set the direction for how NHS Cheshire and Merseyside will focus its involvement resources:

1. **Ensure that involvement is fully embedded** into our commissioning, governance and decision-making practices as an organisation.
2. **Offer a wide range of involvement opportunities** to help maximise participation.
3. **Focus on hearing from under-represented voices** underpins our involvement planning.
4. Design involvement routes which **recognise different needs, preferences and styles** and aim to address any key barriers.
5. **Prioritise hearing from people with lived experience** wherever possible in our involvement activities.
6. **Create inclusive mechanisms for involving people** in specific programmes of work, including major service change.
7. **Help staff to understand our involvement duties** so that opportunities for are not missed.



8. **Go where people already are** rather than expecting people to engage through corporate or organisational channels.
9. **Use existing networks, forums, groups** and community infrastructure to reach people where possible, rather than ‘reinventing the wheel’.
10. **Demonstrate how people’s feedback will be used** to improve services, influence decision making, and shape future planning.
11. **Share the insights we gather with key partners** to maximise the impact of involvement.
12. **Look for opportunities to collaborate and co-deliver involvement** activity, making the most of skills, expertise, and opportunities to share learning and best practice.

6. Our involvement infrastructure

Our involvement approach is usually designed around the specific needs of each project, programme or piece of work, and how best to engage with the audience we want to reach.

However, there are four key mechanisms which underpin all of our work – and the following slides provide more information about each:

- **Involvement methods**
- **Communications channels**
- **Working with key partners**
- **Involvement governance**

As with all elements of this plan, this infrastructure will be reviewed at regular intervals to ensure that it is still fit for purpose, and so that our approach can grow and evolve over time.

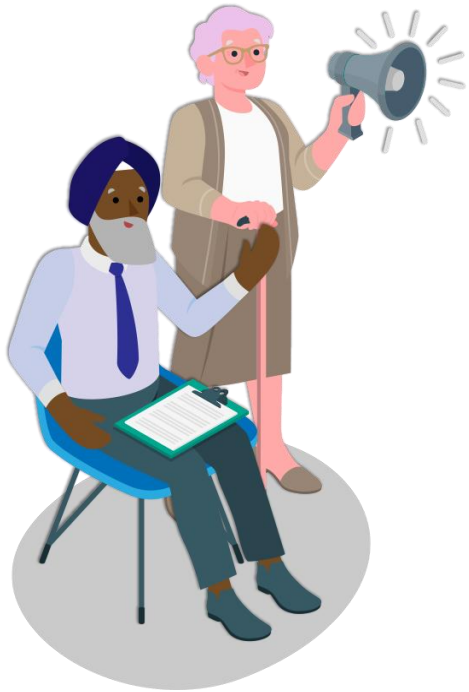


1. Our main involvement methods

- Surveys, questionnaires, quick polls and digital engagement
- Co-design workshops
- Focus groups, 1:1 interviews and direct outreach
- Patient advisory or reference groups (in–person/virtual)
- Lived experience panels
- VCFSE partnerships
- Community Voices (our involvement database and newsletter)
- Existing NHS patient forums, networks and groups



2. Our communications channels



Face-to-face – one-to-one and group meetings, briefings (in person and virtual), drop-ins, workshops, events and exhibitions, bi-monthly Board meetings

Media – local, national, print and online newspapers, specialist magazines, radio and TV

Print – letters, leaflets, newsletters, print advertisements, posters, questionnaires, magazines, printed reports, consultation and engagement materials

Internal digital – our staff intranet, all-staff/team email announcements and briefings, email bulletins and lock-screen messages, staff networks

External digital – our own website/s, digital engagement platform/s, partner websites, bulletins, blogs and vlogs

Social media – X (formerly Twitter), Facebook, Instagram, YouTube and LinkedIn

Marketing – banner promotion on websites, external digital advertising, print, radio, television and out-of-home advertising, promotion via third-party, direct mail to homes

Partner networks – engaging with key partners/networks to amplify messages as appropriate



Addressing digital exclusion

Like many organisations, our core communications channels are largely online.

Although we will always take a ‘digital first’ approach as a cost-effective and environmental way to reach a wide range of people, **we will always provide alternative routes for those who are not digitally engaged**.

This typically includes providing a telephone contact point and paper-based alternatives.

At times, we’ll also work with key partners in the VCFSE sector to help us engage with this group in a more targeted or focused way.

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3. Working with our key partners

NHS staff and volunteers

We recognise that our NHS staff and volunteers are a key stakeholder, both as individuals with vast experience of the services they work in or alongside, and as members of our local population and users of services themselves.

Key internal channels we will use to communicate with and involve our staff include:

- **Staff Hub** (intranet)
- **Staff internal newsletters** (email)
- **Staff briefing sessions** (MS Teams)
- **Staff networks and interest groups** (face to face and online)



Wider NHS system partners

Wherever possible we aim to work with existing NHS partners, patient experience groups, forums and networks rather than reinvent the wheel, such as:

- **Patient Participation Groups (PPGs) –** engaging with patient representatives from individual GP practices
- **Patient Advisory or Reference Groups –** engaging directly with those with lived experience of specific services
- **Primary Care Networks (PCNs) –** engaging with patient voice representatives from networks of GP practices known as primary care networks (PCNs)
- **NHS Trust Patient Experience Teams** – engaging with specific patient groups, networks and forums via in-house teams in individual NHS Trust organisations
- **Healthwatch and VCFSE sector** – partnering with sector leaders to help us hear from different community voices



Healthwatch & VCFSE sector partnership

Some of the main ways we work together include:

- **Holding regular update meetings with sector leaders** to discuss upcoming work and identify opportunities for collaboration.
- **Sharing information** on involvement opportunities with local community organisations as relevant to help maximise our reach into communities and encourage participation.
- **Inviting organisational representatives to be involved in the planning and delivery of specific engagement projects/workstreams** particularly where they are recognised as having knowledge or expertise which is well aligned.
- **Helping to recruit individuals to participate in specific activities** such as service development workshops, 1:1 interviews, focus groups or lived experience panels.
- **Partnering with the Cheshire and Merseyside VCFSE Alliance,** which represents the sector across the region, to ensure that the VCFSE sector and the communities they represent are fully represented in our involvement and decision-making processes.
- **Commissioning community organisations to help us deliver targeted engagement activities** particularly to communities and people that we might otherwise struggle to engage.



4. Involvement governance

It's also crucial that NHS Cheshire and Merseyside has a robust governance process in place for involvement. Some of the main ways we are working to ensure this include through:

- **Implementing 'early engagement' scoping sessions** to help different teams ensure that involvement is factored in at an early stage in every programme or project.
- **Aligning involvement activity with Board and Committees processes** so that decisions are informed by lived experience and community perspectives wherever possible, alongside clinical, operational, and financial perspectives.
- **Ensuring clear governance processes are agreed**, **understood and fully described** in all of our communications and engagement plans.
- **Ensuring the VCFSE sector is fully embedded in our involvement, governance and decision-making processes –** working through both ICB structures and the sector's own structures via our partnership with the Cheshire and Merseyside VCFSE Alliance.
- **Providing structured systems and processes for planning, delivering and reporting** on our involvement activities.

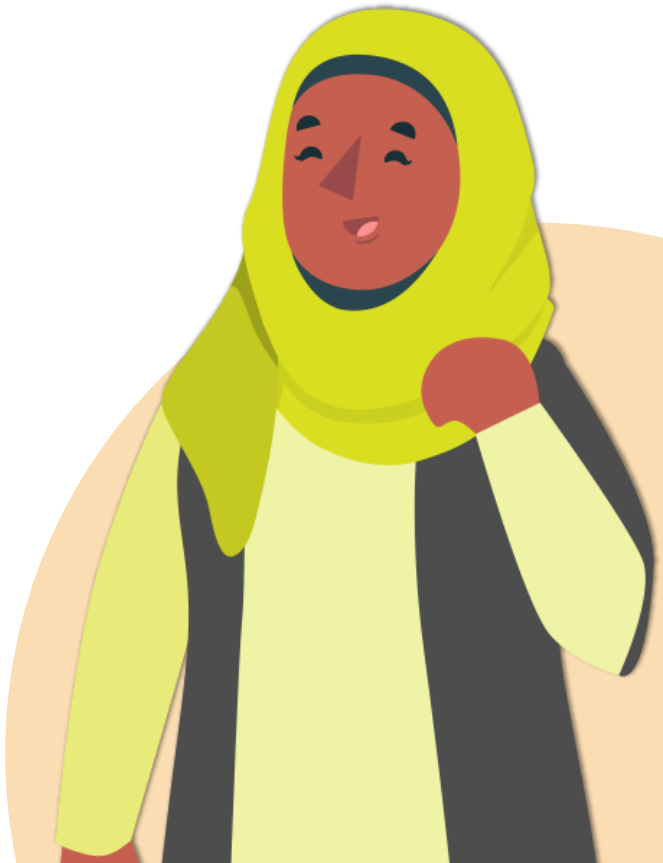
7. Service change

Our involvement duties play a key role when we are considering potentially making changes to services, and it's crucial that that we have clear arrangements in place for involving people from the outset of each programme.

It's important to understand that **our approach to engagement delivery for service change is not a 'one size fits all' model.**

Our planning is tailored according to the type of services we are looking at changing, the scale of potential impact, and the needs of the patients and communities affected by a proposed change.

For example, while some service change processes would require mass marketing to reach a wide audience, some service changes will only affect a much more targeted group of people.





Hearing from those most directly impacted

However, one of the key principles underpinning all of our service change work is that our involvement activities will be tailored to ensure that we hear from those most directly impacted.

This means **we will always try to directly involve those with lived experience** of the condition, service or type of care we are looking to improve as much as is practicable.

Some of the main ways we do this are through:

- patient focus groups
- 1:1 conversations
- lived experience panels
- co-creation workshops

Our commitment to equality, diversity and inclusion

Alongside our statutory public involvement duties, the NHS is expected to meet the **Public Sector Equality Duty** and the **Accessible Information Standard.**

This means all of our public involvement engagement activity should be actively designed to support people with protected characteristics, social inclusion groups and those who experience health inequalities or other barriers to access to be able to participate in a meaningful way.

As part of this, we will work closely with our Equality, Diversity and Inclusion (EDI) leads to ensure that Equality Impact Assessments (EIAs) and Quality Impact Assessments (QIAs) inform our involvement approach.





Maximising inclusion and participation

Some of the main ways we currently do this are outlined below, although we are always looking to enhance this offer and make our processes more inclusive:

- Providing paper-based alternatives of digital materials and questionnaires
- Offering Easy Read, large print and British Sign Language (BSL) translations as standard
- Signposting people to a single point of contact for requesting other languages or formats as required
- Partnering with local community organisations as trusted partners/advocates to help maximise our reach into lesser heard communities
- Building equalities monitoring questions into all our engagement activities
- Using real-time data monitoring to identify and address any gaps in reach, and course correct where possible
- Disaggregating data to help us identify if any communities are disproportionately impacted to help us mitigate against this.

8. Feedback and reporting

Making sure that we ‘close the loop’ on involvement activity by providing timely feedback to those who took part is an important part of ensuring that involvement is a **genuine, two-way process.**

We do this by in two main ways:

- publishing engagement reports detailing key findings from the feedback we have received
- proactively sharing these reports and summaries of key insights with a wide range of partners and stakeholders



9. Monitoring and evaluation



We aim to **build clear feedback measures** into all of our engagement plans and activities to help us understand the effectiveness of different channels and methods.

For example, we will often ask people to tell us where they heard about a particular engagement opportunity so that we can consider this in future planning.

Forums such as specific communications and engagement delivery groups or wider programme reference groups also allow us to discuss our effectiveness and help **embed continuous learning and improvement** into our involvement work.

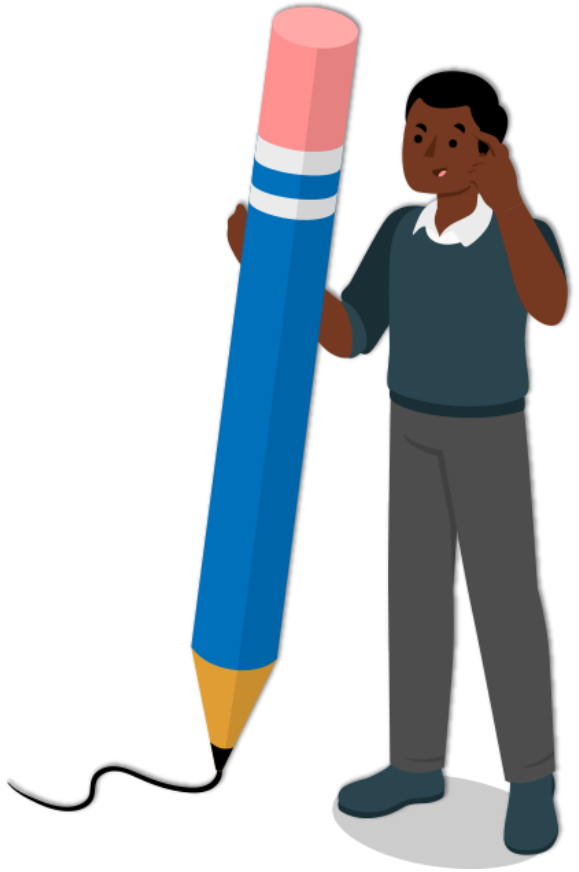
Monitoring and evaluation

In practice, this means that we will continually measure:

- **Reach:** Assessing who is engaging, including the overall number of participants - *it is proportionate?*
- **Diversity:** Assessing the diversity of those involved, with a particular focus on inclusion of underserved and underrepresented groups – *is it representative?*
- **Quality:** Evaluating how well engagement activities are delivered, including the extent to which they are accessible, inclusive, and meaningful for participants – *is it effective?*
- **Impact:** Demonstrating how engagement has influenced decision-making, service design, and policy development – *is it meaningful?*
- **Outcomes:** Assessing the longer-term impact of engagement on services and population health outcomes, including whether changes have led to improvement – *is it impactful and making a difference?*

NHS
Cheshire and Merseyside

Part 2: Key actions to take forwards in 2026/27



Key actions to take forwards

The Communications, Engagement and Public Affairs Team is developing a detailed action plan to help enhance our involvement work across a number of identified key themes over the coming year.

These include:

1. Improving our involvement infrastructure
2. Supporting commissioning teams
3. Developing involvement in primary care
4. Developing involvement in neighbourhood teams
5. Closer partnership with the VCFSE sector
6. Planning, reporting and feedback

This document is only designed as a high-level summary of planned work. Detailed work plans will be developed internally to help take each of these action forwards.

1. Improving our involvement infrastructure

Below is a high-level summary of some of the identified ways in which we plan to enhance our involvement infrastructure over the coming year include:

- **Enhancing 'Community Voices'** by growing its offer, promoting it more widely, and developing a regular newsletter rhythm.
- **Expanding our stakeholder mapping and engagement** capability to broaden our reach.
- Fostering **closer collaboration with NHS Trust communications teams** to support capacity building and the sharing of best practice.
- **Setting up a Patient Engagement, Involvement and Experience network** with key system partners as a network of community networkers.
- **Regularly meeting with VCSFE sector leaders** (monthly or as mutually agreed) to discuss opportunities for collaboration.



2. Supporting commissioning teams

Although the communications, engagement and public affairs team have specific responsibilities for involvement, we want to ensure that involvement is recognised as part of everyone's core business. To support this, we will be:

- **Running listening sessions with commissioners** to understand what will help them to embed involvement into every part of the commissioning cycle.
- **Delivering bespoke training sessions** for key commissioning teams to explore how we can do this more effectively, where needed.
- **Developing supporting toolkits, templates and resources** to support their work to continuously involve patient voice.



3. Developing involvement in primary care

As most people's main touchpoint with NHS services, general practice presents a great opportunity to engage with people, but the skills and capacity to support patient involvement within primary care can be limited.

We are already working with Patient Participation Groups (PPGs) at individual GP practices and Primary Care Networks (PCNs) to help harness patient insights and will be refreshing and revisiting some of this work over the coming year by:

- Re-running the offer of **workshop sessions** and **refreshing supporting involvement toolkits** for PPGs and PCNs.
- Exploring how we can also potentially **replicate this work with other areas of the primary care system** that we now commission e.g. dental, pharmacy, ophthalmology.



4. Developing involvement in Neighbourhoods

We recognise a key part of the government's 10 Year Health Plan is the development of more local systems known as neighbourhoods, and that these need to be factored into our future plans.

Neighbourhoods bring together GP practices with wider community health teams, focused on serving populations of 30,000 to 50,000 people, with an emphasis on shifting care out of hospitals and into communities to deliver more proactive care and prevention of ill health.

As local neighbourhood systems become more developed across Cheshire and Merseyside, we will be working more closely with Neighbourhood teams to explore how we can best support them and harness their potential to involve people and communities in shaping local care solutions. This includes through:

- Scoping opportunities with Neigbourhood leads/managers
- Close involvement with early pilots



5. Closer partnership with the VCFSE sector

Building on our shared understanding of partnership with the VCFSE sector in Cheshire and Merseyside, we want to continue to ensure that we centre the voices of local communities. Specific involvement actions include:

- **Expanding our stakeholder mapping and engagement** capability – with a particular focus on growing our partnerships and networks with VCFSE partners and community groups.
- **Involving VCFSE partners in more of our planning and delivery** around specific involvement projects and programmes of work, including major service change.
- **Regularly meeting with Healthwatch VCSFE sector leaders/networks** to discuss shared opportunities for collaboration.



6. Planning, reporting & feedback

- Improving planning processes, including through **early scoping sessions and supporting documents** to ensure earlier conversations about how we include patient voice in all change processes.
- Refreshing arrangements for **recording any involvement activity taking place** in the organisation.
- Creating and promoting **opportunities for ongoing public feedback** – including via our Community Voices channel and email inbox.
- Demonstrating how we have used insights more consistently by developing a '**You Said, We Did'** feedback and reporting style.
- Creating **an internal 'Insight Library**' so that any patient insight gathered is not 'lost' once a project or programme cycle is finished but can be accessed by other teams to support continuous improvement.

11. Tell us what you think

As part of our collaborative approach to involvement, over the coming months we'll be sharing this plan with a range of involvement partners for feedback.

This is a 'live plan' and we will be continuing to refine and revise elements of it, as we move into delivery phase, in close conversation with key partners.

We're also always keen to hear what people think about our approach to involvement, and how we can improve what we do.

You can provide your views and input into our involvement work at any time by emailing us at: **engagement@cheshireandmerseyside.nhs.uk**



Meeting of the Board of NHS Cheshire and Merseyside

26th November 2026

ICB Governance Update and Corporate Governance Handbook

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

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

REPORT SUMMARY SNAPSHOT

<table>
<tr><th>Required Information</th><th colspan="5">Details</th></tr>
<tr><td>Responsible Executive Director</td><td colspan="5">Ben Vinter, Executive Director of Corporate Services and Governance</td></tr>
<tr><td rowspan="2">Report approval</td><td>By</td><td colspan="4">Ben Vinter, Executive Director of Corporate Services and Governance</td></tr>
<tr><td>Date</td><td colspan="4">2/11/26</td></tr>
<tr><td>Presented by</td><td colspan="5">Ben Vinter, Executive Director of Corporate Services and Governance</td></tr>
<tr><td rowspan="3">Ask of the Board</td><td colspan="2">Approval</td><td>✓</td><td>Decision</td><td></td></tr>
<tr><td colspan="2">Endorsement</td><td></td><td>Ratification</td><td></td></tr>
<tr><td colspan="2">Receive assurance</td><td></td><td>Note</td><td></td></tr>
<tr><td>Route to Board – where has this report been discussed</td><td colspan="5">Following the issuance of enforcement undertakings, the ICB has undertaken a comprehensive review of its governance arrangements to strengthen oversight, assurance and accountability. Key actions have included:

• Review of Board committee structures, membership and leadership arrangements by the Chair.
• Strengthening of the Executive Committee.
• Committee effectiveness reviews and refresh of all Committee Terms of Reference.
• Development of an ICB Governance Handbook, reviewed and endorsed in principle by the Audit Committee.
• Review of a revised Risk Management Strategy aligned to the ICB's purpose and operating model.
• Review and recommended approval of a revised Scheme of Reservation and Delegation reflecting the new organisational model.

The enclosed Governance Handbook is a key output of this programme. It consolidates the ICB's governance framework into a single reference document, providing clarity on decision-making, accountability and assurance arrangements for Board members, staff and system partners.
The handbook incorporates learning and recommendations arising from the NHS England enforcement undertakings, the MIAA Governance Review, committee effectiveness assessments, and the review of committee Terms of Reference.</td></tr>
</table>

<table>
<tr><td></td><td colspan="4">It reflects the actions taken to strengthen governance across the organisation and supports the Board's commitment to continuous improvement.

In addition, the Board is asked to approve the establishment of a People and Culture Committee to provide Non-Executive Director oversight and support the development of the ICB as it further embeds its strategic commissioning role.</td></tr>
<tr><td rowspan="2">ICB Strategic Objective(s) the report relates to</td><td>Tackling Health Inequalities in access, outcomes and experience</td><td></td><td>Improving Population Health and Healthcare</td><td>✓</td></tr>
<tr><td>Enhancing Productivity and Value for Money</td><td>✓</td><td>Helping to support broader social and economic development</td><td></td></tr>
<tr><td>Board Assurance Framework Risk(s) the report relates to*</td><td colspan="4">P17: Workforce Capacity, Capability and Morale
Strong governance, clear accountability and effective decision-making arrangements are essential to organisational effectiveness and leadership capability.

P13: Inability to achieve financial sustainability and productivity
Strong governance and assurance arrangements support effective stewardship of resources and organisational decision-making.</td></tr>
<tr><td rowspan="4">Financial Implications*</td><td>Yes</td><td></td><td>No</td><td>✓</td></tr>
<tr><td colspan="4">If Yes:</td></tr>
<tr><td colspan="3">Have the financial implications been reviewed by the Director of Finance</td><td>×</td></tr>
<tr><td colspan="3">Has a budget been identified</td><td>×</td></tr>
<tr><td>Legal Implications*</td><td colspan="4">N/A</td></tr>
<tr><td>Conflicts of Interest associated with this report</td><td colspan="4">N/A</td></tr>
<tr><td rowspan="4">Impact assessments undertaken*</td><td colspan="3">Equality</td><td>×</td></tr>
<tr><td colspan="3">Quality</td><td>×</td></tr>
<tr><td colspan="3">Data</td><td>×</td></tr>
<tr><td colspan="3">Sustainability</td><td>×</td></tr>
<tr><td>Public or Clinical engagement undertaken</td><td colspan="4">The handbook has been informed by governance reviews, committee effectiveness assessments, and engagement with Committee Chairs, Executive Leads and governance colleagues as part of the governance improvement programme. Subject to Board approval, it will be published on the ICB website to promote transparency and provide an accessible reference for staff, partners, stakeholders and the public.</td></tr>
</table>

ICB Governance Update and Corporate Governance Handbook

1. Purpose

1.1 The purpose of this paper is to present the Board with the newly developed Corporate Governance Handbook for ratification.

2. Executive Summary

2.1 Since establishment in July 2022, NHS Cheshire and Merseyside has maintained a comprehensive suite of governance documents, including its Constitution, Scheme of Reservation and Delegation, Standing Financial Instructions, Committee Terms of Reference, Risk Management Framework and associated governance policies. These documents have continued to evolve through Board and committee approval processes, including the approval of a revised Constitution and refreshed Committee Terms of Reference during 2026.

2.2 The Corporate Governance Handbook has been developed to consolidate these existing governance arrangements into a single reference document. Whilst not a statutory requirement, the handbook provides a comprehensive overview of the ICB's governance, decision-making, assurance, risk management and accountability frameworks, improving accessibility, transparency, consistency and organisational memory.

2.3 The handbook does not introduce significant new governance arrangements. Rather, it consolidates existing Board and committee-approved governance documents, incorporates the outputs of the governance improvement programme, and provides a single, coherent overview of how the ICB's governance framework operates. Following approval, it will be maintained as a living document and updated to reflect future developments.

2.4 This report also seeks Board approval for the establishment of a new People and Culture Committee. Developed in response to a Board request, the Committee will provide oversight and support delivery of the ICB's people and culture agenda, representing a timely development following completion of the organisational change process.

2.5 The handbook incorporates the updated Operational Scheme of Reservation and Delegation (oSoRD) and references the Scheme of Reservation and Delegation (SoRD), following review by the Finance, Investment and Contracting Committee. The proposed amendments reflect organisational changes, including updates to executive roles and accountabilities and the

realignment of Information Governance, SIRO and Caldicott Guardian responsibilities. These changes are administrative in nature and do not alter delegated authorities or decision-making responsibilities. A wider review of the SoRD and oSoRD is underway, with a further report due to be presented to the Board in January 2027.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **APPROVE** the Corporate Governance Handbook as the consolidated reference document for the ICB's governance framework.
- **APPROVE** the establishment of a People and Culture Committee
- **NOTE** that the governance schematic contained within the handbook will be updated to reflect the above detailed committee establishment when and if this decision is taken.
- **NOTE** that the handbook brings together existing governance arrangements and governance documents previously approved through established Board and committee processes.
- **APPROVE** delegated authority to the Executive Director of Corporate Services and Governance to make future minor administrative, legislative and housekeeping amendments to the handbook, with substantive governance changes continuing to be presented through the appropriate committee and Board approval processes.
- **APPROVE** the updates made to the OSoRD as recommended by the FICC and incorporated within the Corporate Governance Handbook.
- **NOTE** that a wider review of the SoRD and OSoRD is underway, with a further report anticipated to be presented to the Board in Q4.

4. Reasons for Recommendations

4.1 The recommendations are intended to strengthen governance, accountability and assurance arrangements across the ICB by consolidating governance documentation, enhancing Board oversight of people and culture, ensuring governance delegations remain aligned to current organisational arrangements, and establishing a proportionate process for maintaining governance documentation. The proposals support delivery of the ICB's governance improvement programme and the Board's commitment to continuous improvement in governance effectiveness.

5. Background

5.1 During 2026, the ICB undertook a significant programme of governance review and improvement to support organisational effectiveness and respond to recommendations arising from the NHS England Enforcement Notice, the MiAA Governance Review, committee effectiveness assessments and wider governance development activity.

5.2 The MIAA Governance Review identified opportunities to strengthen governance by clarifying decision-making arrangements, streamlining committee responsibilities, enhancing Terms of Reference, improving alignment between Board risks and committee oversight, strengthening assurance reporting, and keeping governance documentation under regular review.

5.3 In response, the ICB has undertaken a comprehensive review of its governance framework, including committee effectiveness assessments, refreshed Terms of Reference and workplans, strengthened alignment between committees and Board Assurance Framework risks, enhanced assurance reporting arrangements, and updates to key governance documentation. Revised Terms of Reference have been reviewed through the relevant committees before submission to the Board.

5.4 The Corporate Governance Handbook is a key outcome of this work, providing a single, accessible source of governance information. It consolidates existing governance arrangements, documents and assurance mechanisms, promoting consistency, transparency and organisational learning while providing a framework for future governance development.

6. Key areas of Note, Discussion and Assurance for the Board / Committee

6.1 The Board should note that the handbook supports the delivery of actions arising from the MIAA Governance Review and wider governance improvement programme. This includes strengthened governance documentation and Committee Terms of Reference, enhanced alignment between committees, risks and assurance arrangements, and support for the embedding of the ICB's revised risk management framework.

6.2 The handbook also incorporates updates to the Operational Scheme of Reservation and Delegation (oSoRD), recommended by the Finance, Investment and Contracting Committee, to reflect current organisational structures, executive accountabilities and Information Governance responsibilities. These amendments are administrative in nature and do not alter delegated authorities or decision-making arrangements.

6.3 Collectively, these changes support governance maturity, organisational transparency and compliance with NHS England governance expectations.

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

Objective One:	**Tackling Health Inequalities in access, outcomes and experience**
Objective Two:	**Improving Population Health and Healthcare**
Objective Three:	**Enhancing Productivity and Value for Money**
Objective Four:	**Helping to support broader social and economic**

development

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

The Governance Handbook supports delivery of the ICB's Five-Year Plan by providing a clear governance framework for decision-making, accountability, risk management and assurance. It strengthens the ICB's ability to operate as an effective strategic commissioner, supports effective oversight of delivery against strategic objectives, and provides the governance foundations required to achieve the ambitions set out within the Plan.

9. Link to meeting CQC ICS Themes and Quality Statements

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

The Governance Handbook supports compliance with the CQC Integrated Care System assessment framework (particularly to leadership QS13 – governance, management and sustainability) by strengthening arrangements for leadership, governance, accountability, risk management and assurance. It provides a clear framework for decision-making and oversight, supports continuous improvement in governance effectiveness, and enhances the ICB's ability to demonstrate transparency, accountability and effective stewardship of public resources.

10. Finance

Not applicable

11. Communication and Engagement

11.1 The handbook supports effective communications and engagement by providing a transparent and accessible description of the ICB's governance arrangements, decision-making processes and accountability structures. This strengthens understanding among staff, partners and stakeholders, supports meaningful engagement in decision-making, and promotes openness and transparency in line with the ICB's statutory duties.

12. Equality, Diversity and Inclusion

Not applicable

13. Climate Change / Sustainability

Not applicable

14. Next Steps and Responsible Person to take forward

14.1 Subject to Board approval, the Governance Handbook will be published on the ICB's internal 'Staff Hub' and public-facing website (and maintained as a 'live document'). The People and Culture Committee will be established, and future substantive governance changes will continue to be brought to the Board for approval.

15. Officer contact details for more information

Stephen Hendry
Head of Governance & Risk
Stephen.hendry@cheshireandmerseyside.nhs.uk

16. Appendices

Appendix One: Draft Terms of Reference for the ICB People and Culture Committee

Appendix Two: Corporate Governance Handbook (2026)

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board

People and Culture Committee

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
27/03/2023	0.1	First draft	All comments incorporated	Vicki Wilson and Suzanne Burrage
04/04/2023	0.2	Updates following initial review and amendments	All comments incorporated	People Team
04/04/23	0.3	No updates made	N/A	Governance Review
25/04/23	0.4	Approved	Approved	Finance, Investment & Resourcing Committee
15/7/26	0.5	Updated with ICB template, following MoC with job titles		Sallyanne Hunter
15/09/26	0.6	Reflect discussions with NEDs to establish a discreet NED focussed forum and align with exec activities		Ben Vinter

Review due: xx

V0.6 approved by the ICB Board on xx

People and Culture Committee

TERMS OF REFERENCE

Constitution	The People and Culture Committee (the Committee) is established by NHS Cheshire & Merseyside Integrated Care Board ("the Board" or "ICB") as a sub-committee of the Board. The Committee is established to oversee the development and implementation of the ICB People Strategy and related workforce work programmes and activity. Its purpose is to provide assurance through the ICBs governance mechanisms in relation to people and culture matters including any wider system considerations and linkages recognising the key workforce contribution to strategic commissioning. The Committee is authorised to investigate any activity within its Terms of Reference. As part of an integrated approach, the Committee must have effective relationships with other key committees and forums to avoid duplication and seek necessary assurance.
Membership	The People Committee will consist of the members detailed below or their deputies who will be required to attend should the member need to send apologies. • NED Chair • Up to two other NEDS • Chief Executive (or nominated Executive) • Chief People Officer • Another Executive Director The following will be regular attendees of the People Committee: • Associate Director of Workforce & OD • Head of HR • Head of Communications and Engagement • FTSU Guardian (Clinical Directorate) • People Programmes & Staff Engagement Programme Lead Other colleagues will attend as and when the agenda requires at the request of the Committee Chair. It is important that members attend the Committee on a regular basis. No more than two meetings should be missed in any one year unless due to extenuating circumstances. Executive members are expected to nominate a deputy to attend in their absence.

	If a committee member or regular attendee is unable to attend the meeting or send a deputy then a formal summary report of progress made against their areas of responsibility should be given, in advance of the meeting, identifying the key issues that should be raised. The Chair will be responsible for agreeing the agenda, ensuring that the business discussed is line with the Committee terms of reference, workplan and within the authority of the committee as outlined within the SORD or Operational SORD. The Chair will ensure the Committee reports the respective Committee business as detailed including associated risks. Recognising the nature and environment of the ICB redesign it is anticipated that a number of meetings might represent shaping discussion and take place informally and remotely. If a recommendation is needed which cannot wait for the next scheduled meeting, the Chair of the committee may conduct business on a virtual basis through the use of telephone, email, or other electronic communication.
Attendance	The Committee will hold its meetings in private. Only members of the Committee have the right to attend Committee meetings, but the Chair may invite others to be regular standing attendees to the meeting or to attend as necessary in accordance with the business of the Committee. 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. The Committee shall be supported with a secretariat function. Duties will include: • ensuring the agenda and papers are distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Director lead • ensure records of declarations of interest are maintained and made available to the Chair • ensure good quality minutes are taken in accordance with the ICBs standing orders and Corporate Standards Manual and agreed with the Chair • ensure minutes of the meeting will be circulated to all Committee members within 7 working days of the meeting, highlighting actions to be undertaken by individual members • keep a record of matters arising, action points and issues to be carried forward • keep a record of the decisions made under the authority of the Committee or made at Committee meetings

Quorum	A Committee meeting is quorate if a minimum of 3 members are present, one of whom must be an Executive Director, and another committee member. To meet the Committee will always be chaired by a NED. If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no recommendations may be agreed. 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.
Frequency/ Duration	Meetings shall normally take place on an alternate monthly basis and there should be no less than four meetings per year. Additional meetings may be arranged from time to time, if required to support the effective functioning of the ICB. The Chair or Chief People Officer may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice or recommendation. In accordance with the ICBs Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.
Authority	The Committee is authorised to: • Investigate any activity within its terms of reference. • Request any information it requires within its remit, from any employee or member of the ICB as outlined in these terms of reference. • Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice. • Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members.

Duties	The Committee's duties are as follows: • Oversee the development, implementation and monitoring of the ICBs People Strategy and corresponding operational delivery plans and providing assurance to the Board that these are being delivered in line with organisational objectives and priorities. • To receive assurance on the local implementation of any national or regional workforce programmes including the 'NHS People Plan' and 'People Promise'. • Approve and review effectiveness of strategies and policies, relating to the management, capacity and capability of the ICBs workforce. • To receive information on the organisation's culture, development opportunities, risks and initiatives that seek to address workforce needs (including recruitment & retention, staff experience, • To receive information on the organisational workforce needs (including recruitment & retention, staff experience, engagement & well-being, equality diversity and inclusion, development of people, and organisational capacity and capability) and receive assurance on the quality and effectiveness of plans • To receive reporting and assurance of delivery against the ICB Organisational Development Plan and activities to develop culture, values and organisational effectiveness. • To receive reporting in respect of strategic workforce planning, development and transformational and innovation programmes. • Oversee development of a framework or environment which cultivates appropriate pan system strategic relationships with Trusts and partners that provides assurance on workforce planning including a wider NHS response to the workforce needs of our ICS • To receive reporting and assurance in respect of the organisational workforce plan. • To receive assurance reporting in respect of any significant organisational change or re-design activities. • Review and receive assurance on any required changes in practice required following any internal enquiries or learning exercises that significantly impact on workforce issues. • Consider any staff surveys or other statutory returns or annual reports related to the people function. Reporting to the Board on any assurance regarding arrangements and delivery of the resultant action plan in relation to the annual staff survey, equality duties and any other statutory reporting requirements • Oversee the development of strategic relationships with partners including further and higher education institutions to ensure NHS is able to influence the supply of practitioners and

	professionals with the skills and competencies required by the organisation. • Reviewing and approving partnership arrangements with staff side organisations. • To review the associated workforce risks and handling plans contained within the Board Assurance Framework and on the Corporate Risk Register. • Receiving and considering issues from other Committees when appropriate and taking any necessary action. • Commission the establishment of any task and finish groups, approve the terms of reference of reporting groups and receiving reports from them for consideration and action as necessary.
Reporting	The Committee shall report to the Board on how it discharges its responsibilities against its terms of reference and work plan. The Committee shall provide a formal assurance report (including risks) to the Board which will draw to attention any issues that require further action or risk handling. The Committee will refer to other Committees or forums, matters considered by the Committee deemed relevant for their attention. The Committee will consider matters referred to it by other Committees also. The annual work plan of the Committee may be reviewed by the Audit Committee at any given time.
Conduct	Members of the Committee will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and any other relevant organisational policies. Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life). Committee Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB. Members are expected to actively contribute to discussion, scrutiny and constructive challenge and to prepare adequately for meetings through review of papers in advance. Members should refer to and act consistently with the ICBs Conflicts of Interest Policy and NHS England guidance: Managing Conflicts of Interest in the NHS: Guidance for staff and organisations. Where any member or regular attendee of the Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Committee, that individual must raise this with the Chair of the meeting (in advance where possible to do so) or at the meeting before the agenda item is considered. The Chair will look

	to determine whether or not that individual participates in the meeting (or part of the meeting) in which the relevant matter is discussed, either by participating in discussion or by voting. A Committee Member or regular participant who is materially conflicted may secure that their appointed substitute attend the meeting (or part of meeting) in the place of that individual if it is to either support quoracy arrangements or the discussion to be undertaken regarding that item. All incidences of declarations made will be recorded and maintained within the ICBs declaration registers. Any breaches with regards to the management of conflicts of interest must also be recorded and reported to the Executive Director corporate Services & Governance. Members of, and those attending, the Committee shall behave in accordance with the Constitution, Standing Orders, and Standards of Business Conduct Policy of each of the partner ICBs. Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.
Other Matters	Review The Committee will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the Terms of Reference will be submitted to the Board of each ICB for approval.

Review due: xx

V0.6 approved by the ICB Board on x

Corporate Governance Handbook

Version 1

November 2026

Version Control

Date Approved by Board	Version	Revision	Comment	Author / Editor
26 November 2026	1.0			S Hendry, Head of Governance & Risk

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1. Introduction

1.1 Purpose of the Handbook

NHS Cheshire and Merseyside's Integrated Care Board (ICB), was formally established on 1st July 2022 and is the statutory NHS organisation responsible for planning, funding and overseeing NHS services for our population of approximately 2.7 million people.

This Governance Handbook provides a single source of reference for the governance arrangements of NHS Cheshire and Merseyside Integrated Care Board (ICB). It describes the frameworks, structures, responsibilities and processes through which the ICB exercises its functions, discharges its statutory duties, manages risk and secures assurance regarding the effective, efficient and lawful use of public resources.

Development of the Governance Handbook

Although not a legal requirement, the ICB's Governance Handbook brings together our governance, assurance and performance management arrangements, promoting consistency and preserving organisational memory.

This Handbook should be read alongside the ICB Constitution, Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation and other key governance documents. Where there is any inconsistency, the Constitution and relevant statutory requirements shall take precedence.

The ICB Governance Handbook will be updated regularly as a routine reference guide for the Board, staff, stakeholders and public and will be published on the ICB's public facing website www.cheshireandmerseyside.nhs.uk

1.2 How the ICB is Governed

The ICB Board is accountable for the exercise of the organisation's statutory functions and retains responsibility for the overall governance, strategy, performance and stewardship of the organisation.

The Board is supported by a committee structure which undertakes detailed scrutiny and oversight on its behalf within delegated authority. Committees receive information regarding performance, finance, quality, workforce, risk and other key areas of organisational responsibility and provide assurance to the Board regarding the effectiveness of internal controls and achievement of objectives.

Assurance is derived from a range of sources including:

- Board and committee oversight;
- Performance and financial reporting;

- Risk management processes;
- Internal Audit;
- External Audit;
- Counter Fraud Services;
- Regulatory oversight and external review activity.

Together these arrangements enable the Board to receive timely assurance, make informed decisions and maintain oversight of the ICB's strategic objectives, statutory responsibilities and risks.

2. Governance Framework

The ICB's governance framework provides strategic oversight, effective decision-making and clear accountability. At its centre is the ICB Board, which is accountable for NHS performance across Cheshire and Merseyside.

This framework aligns strategy, commissioning, improvement and delivery and is the mechanism through which all decision points are exercised. The principal tasks of the ICB Board are to:

- Ensure good corporate and clinical governance throughout the local healthcare system
- Set the strategic direction for the ICB
- Provide public leadership for the transformation of the NHS and the local healthcare system and uphold the best principles and values within the public sector
- Review the performance of the ICB in achieving nationally and locally set objectives
- Receive and review the reports of activities carried out by the ICB

In carrying out these tasks, all members of the ICB's Board are jointly and equally responsible for its decisions and actions.

Non-Executive Directors have a specific contribution to make in bringing an external perspective to the ICB Board's consideration and in being able to question and challenge the executive directors from a position of independence and detachment.

2.1 Regulatory Framework

Two national bodies play an important role in providing external oversight and assurance in relation to the ICB.

- **The Care Quality Commission (CQC)** is the independent regulator of health and social care services in England. CQC regulates providers of health and care services, including NHS Foundation Trusts, through registration, inspection, monitoring and, where necessary, enforcement action. Whilst CQC has powers to assess how effectively Integrated Care Systems (ICSs) are working together

to improve outcomes and reduce inequalities, it does not regulate or performance manage ICBs in the same way as healthcare providers.

- **NHS England** is the principal oversight and accountability body for ICBs. It is responsible for assessing ICB performance, supporting improvement, monitoring the delivery of statutory duties and ensuring effective stewardship of public resources. NHS England provides assurance in relation to the ICB's leadership, governance, operational performance and financial sustainability.

The NHS England Oversight Framework provides the primary external assurance and accountability mechanism for ICBs, setting expectations for performance, leadership, governance, risk management and financial stewardship. The ICB's governance arrangements should support the Board in overseeing these requirements effectively, ensuring clear accountability, robust assurance processes and the effective management of risk and performance.

The NHS England Annual Assessment of Integrated Care Boards (ICBs) is the formal process through which NHS England evaluates each ICB's effectiveness in discharging its statutory functions and responsibilities. The assessment considers areas including leadership, governance, financial sustainability, delivery of national priorities, population health improvement and the reduction of health inequalities. The assessment provides independent assurance regarding the ICB's performance and organisational capability, identifies areas of good practice and improvement, and informs the level of support, oversight and intervention required by NHS England.

2.2 The ICB Board Membership

The ICB Board is responsible for setting overall strategy, approving major decisions, and holding the organisation to account for delivery, quality, and financial sustainability. Decisions reserved to the ICB Board are set out in this Governance Handbook. The ICB Board retains ultimate accountability for outcomes, risk, and stewardship of public resources.

The Health & Care Act 2022 sets out the minimum membership requirement of the ICB Board. NHS Cheshire & Merseyside ICB will comprise the following members:

- Chair
- Chief Executive
- NHS and Foundation Trusts Partner Members
- Local Authority Partner Members
- Primary care medical services Partner Members
- Executive Director of Finance & Contracting
- Executive Director of Health & Integrated Commissioning
- Executive Clinical Director
- Executive Director Corporate Services & Governance
- Executive Director of Strategy & Transformation
- Six Non-Executive Directors

The ICB has also agreed the following additional members as participants at its meetings to inform decision-making and the discharge of the ICB's functions as it sees fit:

- Voluntary, Community, Faith and Social Enterprise (VCFSE) Partner Member
- Healthwatch representative

Details of the current members of the ICB Board, Executive Directors, Non-Executive Directors who attend the meetings of the ICB Board are available on the ICB website www.cheshireandmerseyside.nhs.uk.

The ICB Board holds its formal meetings in public. However, these are not 'public meetings' in the normal sense but are meetings held in public. While members of the public may attend and observe discussions, they cannot participate in or ask questions during the meeting. This essentially means that the public are entitled to attend and listen to the ICB Board discussion, but they are not able to take part or ask questions during the formal meeting.

2.3 ICB Board Meetings

The ICB Board will meet in public at least 6 times a year. All ICB Board meeting papers will be published with the agenda on the ICB's website. Exceptions to this may be made for a limited number of papers that are deemed confidential - either because they are commercially sensitive or contain information that concerns an identifiable individual or any items where their disclosure might prejudice the effective conduct of public affairs.

The ICB Board may decide to discuss a *limited* number of items in private, where publicity would be prejudicial to the public interest either because the subject matter is confidential or for other reasons stated in the resolution, but meeting held in public will receive reports on and discuss:

- Strategy
- Quality, performance and finance
- Governance
- Major investment decisions

Meetings of the ICB Board will be held at regular intervals at such times and places as the ICB Board may determine, as set out in the annual cycle of business published on the ICB's public facing website. Agendas and papers for ICB Board and committee meetings open to the public (including details about meeting dates, times, and venues) will also be published on the ICB's website.

At the Chair's discretion, meetings held in public may include a 'Questions & Answers' session during each agenda where members of the public are able to ask questions, which have been submitted in writing ahead of the ICB Board meeting.

To ensure adequate preparation time, questions should be received within 2 working days in advice of the ICB Board meeting. Whilst 'late' questions will be considered, these will only be at the discretion of the ICB Chair.

2.4 Matters reserved to the Board

The ICB has a Scheme of Reservation and Delegation which sets out those matters that are reserved to the ICB Board and cannot be delegated, together with those responsibilities delegated to committees, sub-committees and officers. The Scheme of Reservation and Delegation is published on the ICB website and forms part of the ICB's governance framework website.

2.5 Cheshire and Merseyside ICB Committee Structure

The ICB Board may establish committees and arrange for the exercise of its functions by those committees, except where such functions are reserved to the ICB Board by legislation, the Constitution, or the Scheme of Reservation and Delegation (SoRD). Committees may establish sub-committees and delegate functions to them where appropriate and within the limits of their delegated authority. The ICB's committees and sub-committees are set out in the Scheme of Reservation and Delegation.

Committees operate under authority delegated by the ICB Board and undertake a combination of decision-making, scrutiny and assurance functions. The responsibilities and powers delegated to each committee are set out in their Terms of Reference, the Scheme of Reservation and Delegation, and this Governance Handbook. Through their oversight of key areas of the ICB's business, committees support the ICB Board in ensuring the effective delivery of its strategic objectives, the management of risk, the stewardship of public resources, and the discharge of its statutory responsibilities.

The Cheshire and Merseyside ICB Board has established the following committees:

1. Audit Committee
2. Remuneration Committee (RemCom)
3. System Primary Care Committee (SPCCC)
4. Quality & Performance Committee (Q&PC)
5. Finance, Investment & Contracting Committee (FICC)
6. ICB Executive Committee
7. Shaping Care Together Joint Committee
8. North West Specialised Services Joint Committee

Area	Lead Committee	Board Assurance
Finance	Finance, Investment & Contracting Committee	ICB Board
Quality	Quality & Performance Committee	ICB Board
Primary Care	System Primary Care Committee	ICB Board

Audit, Risk & Internal Control	Audit Committee	ICB Board
Workforce & Organisation Development	Executive Committee	ICB Board
Strategy & Transformation	Executive Committee	ICB Board
Digital & Information Governance	Executive Committee	ICB Board

NHS Cheshire & Merseyside ICB Governance Schematic can be found at **Appendix 1**, along with the Terms of Reference for these committees which are included within **Appendix 2** of this Governance Handbook.

A range of delivery groups, programme groups, steering groups and other forums support the work of the ICB Board, its committees and sub-committees. These arrangements provide advice, support delivery, oversee the implementation of programmes and workstreams, and contribute to the assurance and decision-making processes of the ICB.

2.6 Statutory Committees of the ICB Board

Of the above committees, the following statutory committees carry out specific governance functions:

- **The Audit Committee (AC)** – supports the ICB Board and Chief Executive by reviewing the breadth and reliability of assurances on governance, risk management, the control environment and the integrity of financial statement and the ICB's Annual Report and Accounts.

- **The Remuneration Committee (RemCom)** – supports the ICB Board by overseeing remuneration arrangements and making recommendations on the remuneration, fees, allowances and terms and conditions of service for senior employees and other individuals providing services to the ICB, in accordance with relevant NHS guidance and the Committee's delegated authority.

2.7 Non-Statutory/Assurance Committees

In addition to the statutory committees, the ICB has established four other key assurance committees:

- **The System Primary Care Commissioning Committee (SPCCC)** – responsible for the review, planning and procurement of primary care services in Cheshire & Merseyside under delegated authority of NHS England.

- **The Quality & Performance Committee (Q&PC)** - responsible for providing assurance regarding the quality and clinical effectiveness of commissioned services, the performance of commissioned services against NHS

constitutional standards and the ICB's compliance with its statutory duties with regards to safeguarding and SEND.

- **Finance, Investment and Contracting Committee (FICC)** – responsible for oversight, assurance and decision making in regard to the ICB's financial sustainability, investment priorities and contracting arrangements, ensuring that financial resources are used effectively to deliver ICB strategic priorities.

- **ICB Executive Committee** - the ICB's central executive leadership and decision-making committee, responsible for overseeing the day-to-day management, performance and delivery of all functions delegated by the ICB Board. It provides strategic leadership and assurance across commissioning, transformation, operational performance, governance, risk management, workforce, digital, partnerships and service improvement, ensuring that the organisation delivers its statutory duties, strategic objectives and commissioning responsibilities.

Sources of ICB Board Assurance

The ICB Board obtains assurance through a range of internal and external mechanisms including:

- Board Assurance Framework (BAF)
- Corporate Risk Register
- Internal Audit
- External Audit
- NHS England oversight
- Counter Fraud
- Executive Assurance
- Performance reporting
- Committee assurance reports.
- Auditor's Annual Report

The ICB Board may establish other Committees and Sub-Committees of the ICB, which will operate under terms of reference and membership agreed by the ICB Board. Appropriate reporting and assurance mechanisms will be developed as part of agreeing terms of reference for Committees and Sub-Committees.

2.8 Other Decision-making Groups

A number of decisions and functions are delegated to be exercised jointly by the ICB and other ICBs/system partners.

Joint Committees

The ICB may establish joint committees with other Integrated Care Boards (ICBs), NHS organisations or partner bodies where this supports the effective discharge of

statutory functions, delegated responsibilities or shared strategic objectives. Joint committees enable partner organisations to make decisions collectively, provide oversight of shared programmes and support the delivery of services across organisational boundaries.

The ICB currently participates in the following Joint Committees:

- **Shaping Care Together Joint Committee** – a joint committee established by NHS Cheshire and Merseyside ICB and NHS Lancashire and South Cumbria ICB to oversee and support decision-making relating to the Shaping Care Together programme and the sustainability of services associated with Mersey and West Lancashire Teaching Hospitals NHS Trust.

- **North West Specialised Commissioning Joint Committee** – a joint committee involving NHS England, NHS Cheshire and Merseyside ICB, NHS Lancashire and South Cumbria ICB and NHS Greater Manchester ICB, established to oversee delegated specialised commissioning responsibilities across the North West.

Health & Wellbeing Boards

The ICB works closely with the nine local authorities across Cheshire and Merseyside and their respective Health and Wellbeing Boards to improve the health and wellbeing of local populations and reduce health inequalities. Health and Wellbeing Boards provide strategic leadership at place level, helping to identify priorities through Joint Strategic Needs Assessments and Health and Wellbeing Strategies. The ICB recognises their important role in supporting the development of neighbourhood health, promoting prevention, integration and collaboration between health, care and community partners

Health & Care Partnership

The ICB is an equal partner with the nine local authorities in Cheshire and Merseyside on this partnership, which has the responsibility for approving an Integrated Care Strategy.

A chart summarising the ICB's governance structure / decision-making framework can be found in Appendix 1.

2.9 Standing Orders

The ICB's Standing Orders (SOs) provide the statutory framework for how the organisation conducts its business. They define the ICB's governance arrangements, including membership, roles and appointments, meeting procedures, internal controls, committee structures, delegated authority, reporting of non-compliance, use of the corporate seal, and the relationship with other policies and regulatory requirements. The Standing Orders are set out in Appendix 2 of the ICB Constitution, which can be found here: nhs-cheshire-and-merseyside-icb-constitutionv14-final.pdf.

2.10 Principles of Good Governance

Good governance is fundamental to the success of the ICB and underpins the way in which the organisation is led, directed and controlled. Effective governance enables the ICB to deliver its statutory functions, achieve its strategic objectives and maintain the confidence of patients, the public, partners and stakeholders. Through robust governance, performance management and contractual arrangements, the ICB seeks to ensure the highest standards of public service, promote a culture of openness, transparency and accountability, and drive continuous improvement in the quality, safety and effectiveness of services across the health and care system. A strong focus on learning, innovation and outcomes supports the ICB in responding to challenges, reducing health inequalities and improving the health and wellbeing of the population it serves.

The ICB is committed to fostering a culture in which challenge is welcomed, risks are identified and managed proactively, and lessons are learned from experience, feedback, assurance activities and external reviews. By embedding continuous improvement throughout the organisation, the ICB seeks to strengthen decision-making, enhance organisational effectiveness and ensure that resources are used wisely to deliver the greatest benefit for local communities.

In respect of the ICB itself, the ICB Board has established a governance framework that enables effective leadership, oversight, scrutiny and assurance, meeting both its statutory responsibilities and recognised standards of good governance. This framework is informed by:

- The Seven Principles of Public Life (the Nolan Principles)
- The principles set out by the Independent Commission on Good Governance in Public Services
- The principles and values of the NHS Constitution
- Relevant legislation, including the Equality Act 2010

All ICB members and employees are responsible for ensuring that the organisation complies with its statutory duties, regulatory requirements, NHS standards and principles of good governance. In carrying out their roles, individuals are expected to act with integrity, openness and professionalism, and to make decisions that are lawful, evidence-based and in the best interests of the organisation, the population it serves and its partners.

The ICB Board, supported by its committees, provides strategic leadership, oversight and assurance, ensuring that the ICB discharges its functions effectively, manages risk appropriately, delivers value for money and operates in accordance with legislative, regulatory and governance requirements. The governance framework supports clear accountability, informed decision-making and effective stewardship of public resources while promoting transparency and continuous organisational improvement.

All ICB staff are expected to adhere to the ICB's Standards of Business Conduct Policy, which can be found here: Standards of Business Conduct Policy - NHS Cheshire and Merseyside.

2.11 Managing Conflicts of Interest

The ICB is committed to ensuring that decisions are taken transparently and in the best interests of the population it serves. The effective management of conflicts of interest is an essential element of good governance and supports public confidence in the integrity of decision-making.

The ICB maintains arrangements to identify, declare, record and manage actual, potential and perceived conflicts of interest in accordance with statutory guidance and NHS requirements.

These arrangements include:

- Maintaining registers of interests, gifts, hospitality and sponsorship;
- Regular declarations of interests by ICB Board members, committee members and employees;
- Declaration of interests at the commencement of meetings;
- Appropriate management and recording of conflicts where they arise;
- Publication of relevant registers in accordance with transparency requirements;
- Specific arrangements for the management of conflicts associated with commissioning and procurement activities.

The Board receives assurance that conflicts are being appropriately managed through established governance processes and periodic review of compliance with the ICB's Conflict of Interest Policy.

2.12 Enhancing ICB Board Oversight

The ICB Board may designate lead responsibility to a Non-Executive Director where required or where this provides additional assurance. Such designation does not diminish the ICB Board's collective responsibility or require the Non-Executive Director to assume operational duties.

In accordance with established NHS governance principles key roles and responsibilities or Non-Executive Director 'Champion Roles' have been aligned to a Non-Executive Director where required and are documented within the ICB's Corporate Governance structure. Executive leadership is provided as follows

ICB Roles	Responsible Lead
Caldicott Guardian	Executive Clinical Director with day to day support from the Chief Nursing Officer

Conflicts of Interest Guardian	Audit Committee Chair (with day to day support from Head of Governance & Risk)
Data Protection Officer (DPO)	Merseyside Internal Audit Agency (MIAA)
Equality, Diversity and Inclusion Lead	Senior EDI Lead
Freedom to Speak Up Guardian	Executive Lead: Executive Director of Corporate Services & Governance Guardian: Associate Director of Nursing & Care (Patient Safety)
Health and Safety	Liverpool University Foundation Hospital Trust (LUFHT)
Information Governance Service	Merseyside Internal Audit Agency (MIAA)
Local Counter Fraud Specialist (LCFS) Lead	Executive Director Finance & Contracting with day to day support from Merseyside Internal Audit Agency (MIAA)
Risk Management Lead	Executive Director of Corporate Services & Governance (with operational support from the Head of Governance & Risk
Senior Information Risk Owner (SIRO)	Ben Vinter with day to day support from Chief Data and Analytics Officer (CDAO)
Whistleblowing Lead	Chief People Officer

2.13 ICB Board and Committee Effectiveness

The ICB is committed to continuous improvement in governance and undertakes periodic reviews of the effectiveness of the ICB Board and its committees. These assessments consider leadership, membership, accountability, reporting arrangements, information quality, decision-making and assurance provision.

Outcomes from effectiveness reviews inform action plans and governance improvement activity, supporting the ongoing development of the ICB Board's governance framework.

3. Scheme of Reservation & Delegation (SoRD)

The SoRD establishes the framework for decision-making within the ICB, setting out which matters are reserved to the ICB Board and which are delegated in accordance with the ICB's statutory powers. All delegated decisions must be exercised in line with, and remain consistent with, the Constitution. The SoRD further details the functions and responsibilities delegated to committees, sub-committees, officers, and other authorised bodies.

The Cheshire & Merseyside ICB SoRD can be found here: cm-icb-sord-v15-march-2026-approved.pdf

The SoRD also incorporates an operational/financial scheme of delegation that determines the delegated financial limits for the Committees of the ICB, the ICB's Senior/Executive Leadership Team, finance officers and other authorised signatories.

The Cheshire and Merseyside ICB SoRD – Operational Limits can be found here: operational-sord-v15-march2026-approved.pdf

4. Policy Framework

The ICB policy framework supports effective governance by providing clear principles and requirements for decision-making, strategic commissioning and the responsible use of resources to improve population health and reduce inequalities.

The ICB maintains a suite of policies, procedures and standards that support compliance and form part of the employment framework. All staff are responsible for familiarising themselves with, and adhering to, the policies and training relevant to their role.

The Cheshire & Merseyside policy documentation can be found here Guidance, policies and standards

5. Internal Control

5.1 Overview

Internal control is the framework of systems, processes and controls that enables the ICB to operate effectively, meet its obligations, achieve its objectives, and manage risk appropriately.

5.2 Board Assurance Framework (BAF)

The ICB Board must be assured that the ICB's systems, processes and people are operating effectively to deliver its strategic objectives and manage risk. To achieve

this, the ICB Board requires clear oversight of its principal risks and the effectiveness of the controls in place to mitigate them.

The BAF is the primary tool through which the ICB Board identifies, monitors and obtains assurance on the principal risks to achieving its objectives. It provides a structured approach to risk management and supports the evidence required for the Annual Governance Statement.

The ICB Board must:

- Establish key goals (strategic & directorate)
- Identify the principal risks that may threaten the achievement of these objectives
- Identify and evaluate the design of key controls intended to manage these principal risks
- Set out the arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk.
- Evaluate the assurance across all areas of principal risk (assurances can be internal or external)
- Identify positive assurances and areas where there are gaps in controls and/or assurances
- Put in place plans to take corrective action where gaps have been identified in relation to principal risks
- Maintain dynamic risk management arrangements, including a well-founded risk register.

For the BAF to be effective, the Executive Directors take the lead for risks assigned to them and ensure that the relevant information is kept up to date and available for reporting to the ICB Board. Each Executive Director has assigned an appropriate risk 'lead officer' from their senior staff to coordinate on their behalf. This is a senior individual who is well-placed to access and interpret relevant risk information and assurance evidence. At the end of each financial year, the Chief Executive considers the BAF and other sources of assurance to complete the Annual Governance Statements. This document is included within the ICB's Annual Report and Accounts and is published as part of the organisation's commitment to transparency and accountability.

5.3 Processes and Procedures

There are two broad categories of internal processes and procedures that support the effective operation of the ICB.

Firstly, there are the governance and internal control document that provide the framework for the conduct of the ICB's business and decision-making processes. These include:

- The Constitution.
- Standing Orders, including the Matters Reserved to the ICB Board and the Scheme of Reservation and Delegation.
- Standing Financial Instructions.

- Prime Financial Policies and other key governance policies approved by the Board.

All ICB Board members and managers should be aware of these documents and, where appropriate, should be familiar with the detailed provisions.

Staff should pay particular attention to the Scheme of Reservation and Delegation, as any action taken outside an individual's delegated authority may have significant implications for both the ICB and the individual concerned.

Secondly, there are risk management, assurance and internal control processes through which the ICB Board gains assurance that risks are being effectively managed and strategic objectives are being achieved. Together these arrangements support the ICB Board Assurance Framework.

5.4 Risk Management

Risk management is the key system through which clinical, organisational, and financial risks are managed by all staff to the benefit of patients, staff, and other stakeholders.

The ICB has a Risk Management Strategy and an associated policy/procedure which:

- Sets out the ICB's risk appetite as contained in the Risk Management Strategy
- Defines the structures for the management, ownership, and oversight of risk and defines the management of situations in which the failure of controls leads to material realisation of risks
- Specifies how both new and existing activities are assessed for risk and incorporated into risk management structures
- Ensures common understanding of the terminology used concerning risk
- Defines and describes the processes and considerations which inform the assessment of risk
- Defines and describes how the risk register is regularly reviewed

The Risk Register is the central record of risks identified across the ICB. It captures risks from all services, departments and corporate functions - including the designated risk owner, risk rating, controls and mitigating actions. The Register provides a comprehensive view of organisational risk and enables the monitoring of progress in managing and reducing risks to an acceptable level.

The Corporate Risk Register contains all risks from the ICB Risk Register which score '12' or greater in their assessment.

5.5 Performance

The ICB Board receives a regular Integrated Performance Report which provides a comprehensive overview of organisational and system performance against key

objectives, priorities and statutory responsibilities. The report brings together performance information and key indicators across a range of domains, including quality, operational delivery, workforce, finance, population health and strategic transformation. It is a key component of the ICB's assurance framework, enabling the ICB Board to monitor progress, identify emerging risks and opportunities, and hold the organisation to account for the delivery of its objectives.

5.6 Annual Governance Statement (AGS)

The ICB Board needs to demonstrate that it has reviewed and been properly informed about the totality of its risks. The Chief Executive is required to sign an Annual Governance Statement (AGS) as part of the statutory Annual Report & Accounts for each ICB, confirming that the ICB Board and the Chief Executive have reviewed the system of internal control and have received assurance on that system.

The AGS is submitted annually to NHS England and typically covers the following:

- The scope of the responsibility of the Accountable Officer (Chief Executive)
- The purpose of the system of internal control
- The ICB's capacity to handle risk
- The risk and control framework
- The process used to ensure that resources are used economically, efficiently, and effectively
- Confirmation that a review of effectiveness has been undertaken and that a plan is in place to address any weaknesses
- The process for maintaining the system of internal control and details of actions planned or taken to deal with any significant internal control issues. These might include:
    - an issue which seriously prejudiced or prevented the achievement of a principal objective
    - an issue which resulted in a need to seek additional funding, or in a significant diversion of resources
    - an issue that the External Auditor or the Head of Internal Audit or the Audit Committee considers to be significant
    - an issue which attracted significant adverse public interest or seriously damaged the reputation of the ICB

The AGS is signed off by the Chief Executive, as Accountable Officer, on behalf of the ICB Board. The Head of Internal Audit provides an annual opinion on the adequacy and effectiveness of the risk management, control, and governance processes to support the AGS. The full AGS can be found in the Annual Report & Accounts.

5.7 Custody of Seal and Sealing of Documents

NHS Cheshire and Merseyside ICB maintains a Common Seal for the execution of documents where legal formalities require its use. The custody and use of the Common Seal are governed by the ICB Constitution, Standing Orders and Scheme

of Reservation and Delegation. A register of all documents sealed is maintained by the Corporate Governance Team.

6.0 Independent Control and Regulation

6.1 Internal Audit

The Internal Audit Terms of Reference provide the ICB with the framework for the provision and conduct of an Internal Audit service, in accordance with the requirements of the NHS Internal Audit Standards, the NHS Audit Committee Handbook (2018) and the ICB's Standing Financial Instructions.

Internal Audit is an independent and objective assurance service which has no executive responsibilities within the line management structure. It has an annual plan focused on key aspects of risk management, control or governance agreed by the Audit Committee which is kept under review to consider any significant changes to the ICB's risk profile.

Internal Audit embraces two key areas:

- The annual provision of an independent and objective opinion to the Accountable Officer (Chief Executive), the Board, and the Audit Committee on the degree to which risk management, control and governance support the achievement of the ICB's agreed objectives
- The provision of independent and objective advisory services to support management in strengthening governance, risk management and internal controls and promoting continuous improvement across the organisation.

The Head of Internal Audit's annual report presents the opinion on the overall adequacy and effectiveness of the ICB's risk management, control, and governance processes. This encompasses an opinion on the ICB's Assurance Framework and other mandated work alongside the conclusions arising from the risk-based internal audit assignments within the plan. The degree to which previous audit recommendations have been acted on also forms part of the opinion.

In addition to the formal annual report, the Head of Internal Audit reports interim progress to the Audit Committee and Accountable Officer in the year. Such interim reports detail objectives, findings, and performance against plan. Additionally, progress against the implementation of agreed recommendations is followed up and reported to the Audit Committee on a regular basis.

6.2 The Head of Internal Audit

The Head of Internal Audit reports to the Audit Committee, with the Executive Director of Finance and Contracting taking executive oversight for the provision of the Internal Audit service (except when this may impinge on the objectivity of the audit).

The Head of Internal Audit (or an appropriate representative of the internal audit team) attends meetings of the Audit Committee unless, exceptionally, the Audit Committee decides that they should be excluded from either the whole meeting or for agenda items.

The Head of Internal Audit has an independent right of access to the Chair of the Audit Committee. In exceptional circumstances, where normal reporting channels may be seen to impinge on the objectivity of the audit, they may report directly to the Chair of the ICB.

If the Head of Internal Audit considers that the level of audit resources or the terms of reference in any way limit the scope of internal audit, or prejudice the ability to deliver a satisfactory service, they will advise the Audit Committee accordingly.

6.3 Fraud and Probity

Managing the risk of fraud, bribery and corruption is the responsibility of the ICB's management, supported by all staff and Board members. The ICB has in place a comprehensive Anti-Fraud, Bribery and Corruption Policy and a nominated Local Counter Fraud Specialist (LCFS) who provides awareness, prevention and investigation services. Key information and resources are available through the ICB's intranet and website.

The relationship between the ICB's Local Counter Fraud Specialist, the Head of Internal Audit and the ICB's Director of Finance & Contracting is conducted in accordance with the requirements of the Government Functional Standard.

6.4 External Audit

The ICB is responsible for appointing its external auditor. The appointment is made following advice from the Auditor Panel, which supports a transparent appointment process and provides assurance regarding the auditor's independence and effectiveness.

The External Auditor's opinion on the annual accounts reports on whether:

- The financial statements give a true and fair view, in accordance with the accounting policies directed by NHS England of the state of the ICB's affairs and of its income and expenditure for the year as then ended.
- The part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by NHS England.
- Information included within the Annual Report is consistent with the financial statements.

In addition, the External Auditor produces an Annual Report which provides commentary on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources. The report considers the external auditor's findings against three key criteria: financial sustainability, governance, and

improving economy, efficiency and effectiveness. The report identifies any significant weaknesses in arrangements and provides recommendations to support continuous improvement.

6.5 NHS England

NHS England maintains oversight of ICBs through a statutory framework of accountability, performance assessment, financial oversight, governance requirements and regulatory intervention. Through the NHS Oversight Framework, annual assessments, planning guidance and assurance processes, NHS England monitors the performance, leadership, governance and stewardship of ICBs, providing support where improvement is required and exercising intervention powers where necessary.

The key governance principle is that although ICBs are autonomous statutory bodies, they operate within a national accountability framework that enables NHS England to obtain assurance and intervene where necessary.

6.6 Care Quality Commission (CQC)

The Care Quality Commission (CQC) has a statutory role in assessing how effectively Integrated Care Systems (ICSs) are working together to meet the needs of their populations. Through its ICS assessment framework, the CQC seeks to evaluate system effectiveness across themes including leadership, integration, quality and safety, and the extent to which partners are working collaboratively to improve outcomes and reduce health inequalities. The assessment considers the contribution of the ICB and its partner organisations in delivering these objectives.

The implementation of the ICS assessment framework has been subject to a number of national pauses and revisions since its introduction, and the approach continues to evolve. Whilst the CQC's findings can provide independent assurance, identify opportunities for improvement and inform national discussions regarding system performance, the CQC does not regulate, performance manage or hold ICBs to account in the same way that it regulates healthcare providers. NHS England remains the principal body responsible for oversight, performance assessment and accountability of ICBs.

Information relating to CQC assessments of health and care providers, together with any published findings from ICS assessments, is available via the CQC website. NHS England publishes annual assessments of Integrated Care Boards in accordance with its statutory responsibilities.

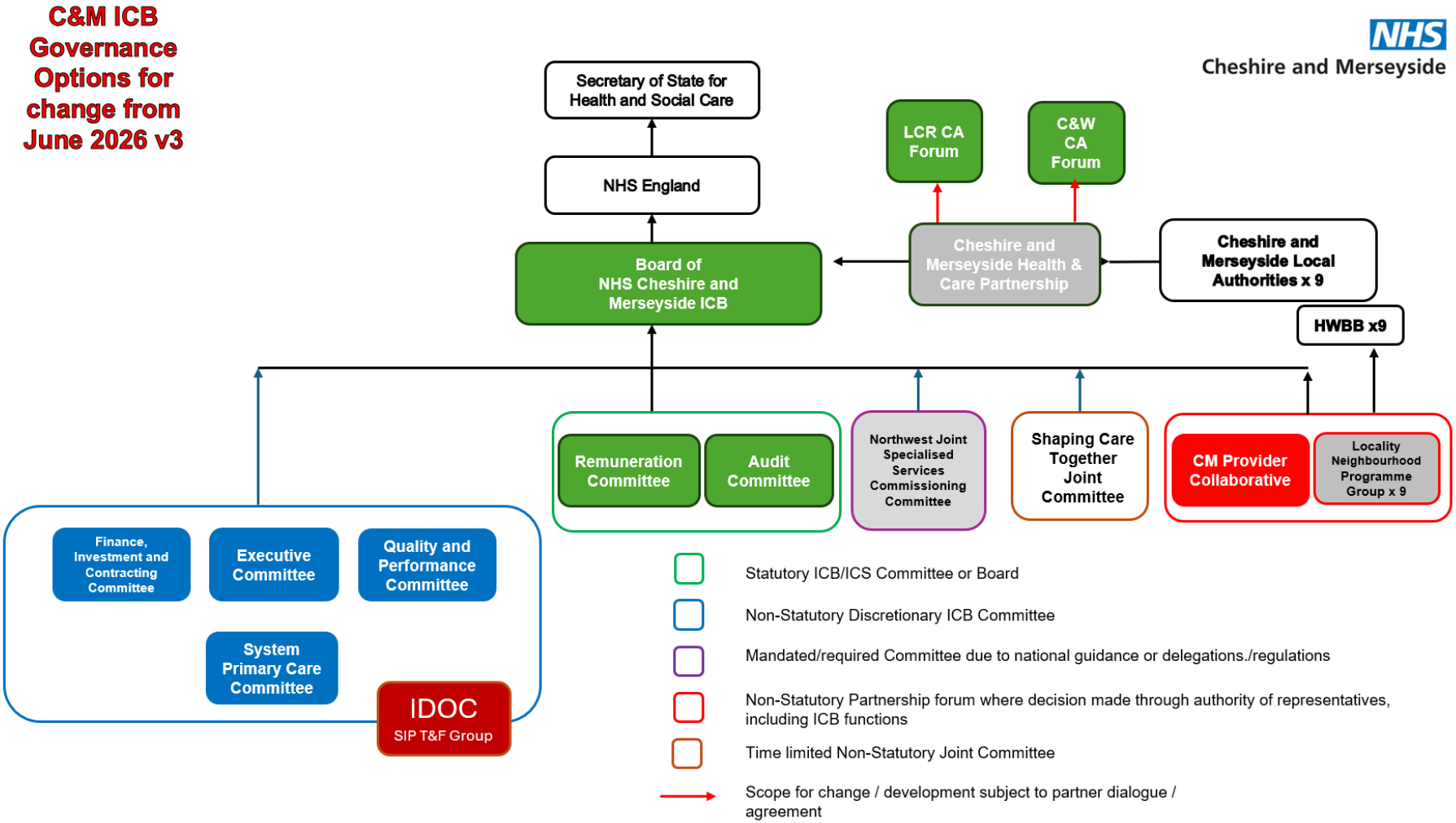
Performance ratings resulting from the review of all NHS Bodies in England are published annually at www.cqc.org.uk

7. Appendices

Appendix 1 - NHS Cheshire & Merseyside ICB Governance Schematic

Appendix 2 - Committee Terms of Reference

Appendix 1 – NHS Cheshire & Merseyside ICB Governance Schematic



Appendix 2 – Committee Terms of Reference

Appendix 2.1 Audit Committee

Appendix 2.2 Remuneration Committee (RemCom)

Appendix 2.3 People and Culture Committee (PCC) – TBC

Appendix 2.4 System Primary Care Committee (SPCCC)

Appendix 2.5 Quality & Performance Committee (Q&PC)

Appendix 2.6 Finance, Investment & Contracting Committee (FICC)

Appendix 2.7 ICB Executive Committee

NHS
Cheshire and Merseyside

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
29.01.26	1.3	Updated TORs to reflect best practice improvements following review against HFMA NHS Audit Committee Handbook		Matthew Cunningham
08.06.26	1.4	Updated ToR into new format, updated job titles following MoC, strengthened following effectiveness survey		Sallyanne Hunter

Review due: November 2027

V1.4 approved by the ICB Board on xx

Audit Committee

TERMS OF REFERENCE

Constitution	The Audit Committee (the Committee) is established by the Board of NHS Cheshire and Merseyside Integrated Care Board ("the Board or "ICB") as a Committee of the Board and in accordance with its Constitution, Standing Orders, Standing Financial Instructions and its Scheme of Reservation and Delegation (SORD). The Audit Committee is established to provide the ICB with independent and objective assurance on the adequacy and effectiveness of the ICB's systems of governance, risk management and internal control across all activities undertaken in support of its statutory duties, strategic objectives and stewardship of public funds. The Committee will maintain a strategic focus on behalf of the Board on principle risks, governance effectiveness, assurance gaps and the overall control environment. The Committee will protect the interests of patients, the public and taxpayers by promoting truth and fairness in reporting, effective assurance arrangements and proportionate systems of internal control. In fulfilling its role, the Committee will provide independent and objective assurance to the Board on the effectiveness of the ICB's: • governance, risk management and internal control arrangements, including the Board Assurance Framework and application of the three-lines model; • internal audit, external audit and counter fraud functions and arrangements; • financial reporting processes, including the Annual Report, Annual Accounts and Annual Governance Statement; • information governance, data quality and cyber security oversight arrangements; • Freedom to Speak Up and wider raising concerns frameworks; and • system (ICS) risk oversight and collaborative assurance arrangements with partner organisations and committees.

Membership	The Committee members drawn from the non-executive members of the ICB Board, 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 at least three non-executive members to the Committee. At least one member must have recent and relevant financial experience (e.g., financial reporting/audit). 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. • 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: • Executive Director of Finance & Contracting or their nominated deputy. • Executive Director Corporate Services & Governance, or their nominated deputy • representatives of both internal and external audit. • individuals who lead on Information Governance, risk management and counter fraud matters. 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. 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. 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	The Committee will be held in private. 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. 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. **The Committee shall be supported with a secretariat function. Duties will include:** • ensuring the agenda and papers are distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Director lead • ensure records of declarations of interest are maintained and made available to the Chair • ensure good quality minutes are taken in accordance with the ICBs standing orders and Corporate Standards Manual and agreed with the Chair • ensure minutes of the meeting will be circulated to all Committee members within 7 working days of the meeting, highlighting actions to be undertaken by individual members • keep a record of matters arising, action points and issues to be carried forward • keep a record of the decisions made under the authority of the Committee or made at Committee meetings
Quorum	For a meeting to be quorate a minimum of two Non-Executive Members of the ICB 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.
Frequency/ Duration	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.
Authority	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. 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 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, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference.

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.

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 work programme will be reviewed regularly to ensure appropriate focus on all aspects of its remit with equity.
	
	The Committees 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.
	
	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. **Internal audit:** The Committee appoints, monitors and evaluates that there is an effective internal audit function that meets the Global 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 GSIAS • **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. **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. **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, and receive periodic assurance from other Board committees to support assurance mapping, identify gaps in assurance and avoid duplication.
	• 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. 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 reasonable- ness 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.
	
	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. **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. **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: o the annual Senior Information Risk Owner (SIRO) report, o the submission for the Data Security & Protection Toolkit (DSPT) o reports on audits to assess information and IT security arrangements, including the DSPT audit o 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. **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:
	  ○ 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.
	
	Conflicts of Interest
	The Committee shall seek assurance 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.
	• **Annual Review:** receive and consider an annual review of the ICBs Conflicts management arrangements

	• **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. **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. The Committee may require attendance from Executive Directors and senior leaders to provide assurance on material governance, risk and control matters within their areas of responsibility. • receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of the ICB's standing orders, in order 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.
Reporting	The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities. The Chair will provide assurance reports to the Board at the subsequent meeting of the Board following a meeting of the Committee and shall draw to the attention of the Board any issues that require disclosure to the Board or require action. 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.
Conduct	Members of the Committee will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and any other relevant organisational policies. Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life). Committee Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB. Members are expected to actively contribute to discussion, scrutiny and constructive challenge and to prepare adequately for meetings through review of papers in advance. Members should refer to and act consistently with the ICBs Conflicts of Interest Policy and NHS England guidance: Managing Conflicts of Interest in the NHS: Guidance for staff and organisations. Where any member or regular attendee of the Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Committee, that individual must raise this with the Chair of the meeting (in advance where possible to do so) or at the meeting before the agenda item is considered. The Chair will look to determine whether or not that individual participates in the meeting (or part of the meeting) in which the relevant matter is discussed, either by participating in discussion or by voting. A Committee Member or regular participant who is materially conflicted may secure that their appointed substitute attend the meeting (or part of meeting) in the place of that individual if it is to either support quoracy arrangements or the discussion to be undertaken regarding that item. All incidences of declarations made will be recorded and maintained within the ICBs declaration registers. Any breaches with regards to the management of conflicts of interest must also be recorded and reported to the Executive Director corporate Services & Governance. Members of, and those attending, the Committee shall behave in accordance with the Constitution, Standing Orders, and Standards of Business Conduct Policy of each of the partner ICBs. Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.

Other Matters	**Review** The Committee will conduct an annual self-assessment, against recognised checklists (HFMAS/NAO tools) so as to review its effectiveness, 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. 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.

Review due: November 2027

V1.4 approved by the ICB Board on xx

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board

Remuneration Committee

Terms of Reference

Document revision history

Date Approved by Board	Version	Revision	Comment	Author / Editor
1 July 2022	1.0	Initial ToRs		Ben Vinter
29 September 2022	V1:1	Changes made by Remuneration Committee at its September 2022 meeting		Matthew Cunningham
13 October 2022	V1.2	Changes made by Remuneration Committee at its October 2022 meeting		Matthew Cunningham
12 September 2023	V1.3	Changes made by Remuneration Committee at its September and December 2023 meeting		Matthew Cunningham
03 October 2024	V1.4	Amendments to TOR to reflect role of Committee in Board member Appointments in line with agreed Board Member Appointments Policy		Matthew Cunningham
5 June 2026 & 7/10/26	V1.5	Updated format. Updated following Chair review. Clarified Deputy Chair arrangements, attendance of the ICB Chair, and management of conflicts of interest relating to remuneration decisions.		Sallyanne Hunter

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V1.5 approved by the ICB Board on xx

Remuneration Committee

TERMS OF REFERENCE

Constitution	The Remuneration Committee (the Committee) is established by the Board of NHS Cheshire and Merseyside Integrated Care Board ("ICB" or "the Board") as a Committee of the Board in accordance with its Constitution, Standing Orders, Standing Financial Instructions and its 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 Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 18 to 20 of Schedule 1B to the NHS Act 2006. The Committee will: • adhere to all relevant laws, regulations and company policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors whilst remaining cost effective • advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments.
Membership	The Committee members shall be appointed by the Board in accordance with the ICB Constitution and as outlined within these Terms of Reference. The Board will appoint no fewer than three members of the Committee, drawn from the Non-Executive Directors of the Board. All Non-Executive Directors of the ICB may be members of the committee recognising that there may be times when the ICB Audit Chair needs to abstain from taking part in the meeting. Other members of the Committee need not be members of the Board, but they may be. The Committee may also choose to appoint other individuals to be members of the Committee, drawn from: • up to two Non-Executive Directors drawn from NHS Providers or neighbouring ICBs, ideally with experience of remuneration committees and / or remuneration decisions for members of Board. When determining the membership of the Committee, active consideration will be made to diversity and equality. The ICB Chair will also receive a standing invitation to attend and will only sit as a member when there is a need to maintain quoracy or when a decision involving ICB Non-Executive Director remuneration or allowances is to be made.

	In accordance with the constitution, the Committee will be chaired by a Non-Executive Director of the Board. The Committee shall appoint a standing Deputy Chair from amongst the ICB Non-Executive Directors who are members of the Committee, excluding the Non-Executive Director undertaking the role of the ICB Audit Chair. In the absence of the Chair, or Deputy Chair, the remaining ICB Non-Executive Directors present shall elect one of their number to Chair the meeting recognising that this may not be the ICB Chair, or Audit Chair. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.
Attendance	The Committee will be held in private. Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee. Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote: • ICB Chair (with a standing invitation to attend) • Chief People Officer or their nominated deputy • • Chief Executive or their nominated deputy • Board and Governance Lead • Independent HR Advisors. 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. **Management of Conflicts of Interest** No individual should be present during any discussion or decisions relating to: • any aspect of their own remuneration • any aspect of the remuneration of others when it has a direct impact on them. **The Committee shall be supported with a secretariat function. Duties will include:** • ensuring the agenda and papers are distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Director lead • ensure records of declarations of interest are maintained and made available to the Chair • ensure good quality minutes are taken in accordance with the ICBs standing orders and Corporate Standards Manual and agreed with the Chair

	• ensure minutes of the meeting will be circulated to all Committee members within 7 working days of the meeting, highlighting actions to be undertaken by individual members • keep a record of matters arising, action points and issues to be carried forward • keep a record of the decisions made under the authority of the Committee or made at Committee meetings
Quorum	For a meeting to be quorate a minimum of two Non-Executive Directors 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, with the exception only being when the Committee is determining the remuneration and allowances of the ICBs Non-Executive Directors. If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. 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.
Frequency/ Duration	The Committee will meet at least twice each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. The Board Chair or Chief Executive may ask the Remuneration Committee to convene further meetings to discuss particular issues on which they want the Committee's advice or agreement. In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.
Authority	The Committee is established by the ICB as a committee of the Board and 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 • obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice • create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of

	reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and SoRD but may/not delegate any decisions to such groups without the approval of the ICB Board • commission, review and authorise policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by the ICB Board. For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the committee being permitted to meet in private. **Decision-making and voting** The Committee has delegated authority from the Board to make decisions on remuneration matters within the scope of these Terms of Reference and the ICB's Scheme of Reservation and Delegation. Where matters fall outside the Committee's delegated authority, or are reserved to the Board, the Committee will make recommendations to the Board for consideration and approval. Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency. Decisions will be taken in accordance with the Standing Orders of the ICB 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.
Duties	The Board has delegated the following functions and duties to the Committee: For the Chief Executive, Directors and other Very Senior Managers: • determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, allowances, pensions and cars • determine arrangements for termination of employment and associated severance payments, and other contractual terms and non-contractual terms • advise on and propose the appointment process for the ICBs Chief

Executive, in line with the national process.

For Partner Members on the Board:

- approve any ICB Pay and Allowances/Benefits policies and frameworks for Partner Members on the ICB Board

For Non-Executive Directors of the Board:

- determine the ICB remuneration policy (including the adoption of pay frameworks)
- oversee contractual arrangements.
  determine Non-Executive Director remuneration and any other allowances (see note below), ensuring that any conflicts of interest are appropriately declared and managed in accordance with the ICB's Standards of Business Conduct and Conflicts of Interest Policy. Decisions regarding Non-Executive Director remuneration shall be made collectively by the Committee, with conflicted individuals withdrawing from the discussion and decision-making process as appropriate.

None of the ICBs Non-Executive Directors will be involved in the decision making regarding the determination of their renumeration and any other allowances. On the occasion where this is required the Committee membership be composed of the ICB Chair and up to two Non-Executive Directors drawn from NHS Providers or neighbouring ICBs.

For all staff:

- determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change).
- oversee contractual arrangements
- determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.
- approve disciplinary arrangements for employees, including the Chief Executive (where he/she is an employee of the ICB).

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

- provide support to the ICB Chair and ICB Chief Executive in the undertaking of Board Member appointments and as outlined within the ICB Board Member Nomination and Appointments Policy
- functions in relation to the performance review/oversight and appraisals for Executive Directors/Senior Directors, including the Chief Executive and the Chair in line with NHSE guidance on appraisals for Chairs and Chief Executives
- oversight of the succession planning for the Board member positions and Executive Directors assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation and including such things as Fit and Proper Person Regulation (FPPR).

Reporting	The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities. The Chair will provide assurance reports to the Board at the subsequent meeting of the Board following a meeting of the Committee and shall draw to the attention of the Board any issues that require disclosure to the Board or require action. Reporting will be appropriately sensitive to personal circumstances and contain no personally sensitive or personally identifiable information. The Committee will provide the Board with an Annual Report timed where possible to support finalisation of the ICB Annual Report and Accounts. The report will summarise its conclusions from the work it has done during the year.
Conduct	**Benchmarking and guidance** The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England, and the wider NHS in reaching their determinations. **ICB values** Members of the Committee will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and any other relevant organisational policies. Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life). Committee Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB. Members are expected to actively contribute to discussion, scrutiny and constructive challenge and to prepare adequately for meetings through review of papers in advance. Members should refer to and act consistently with the ICBs Conflicts of Interest Policy and NHS England guidance: Managing Conflicts of Interest in the NHS: Guidance for staff and organisations. Where any member or regular attendee of the Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Committee, that individual must raise this with the Chair of the meeting (in advance where possible to do so) or at the meeting before the agenda item is considered. The Chair will look to determine whether or not that individual participates in the meeting (or part of the meeting) in which the relevant matter is discussed, either by participating in discussion or by voting. A Committee Member who is materially conflicted may secure that their appointed substitute attend the meeting (or part of meeting) in the place of that individual if it is to either support quoracy arrangements or the discussion

	to be undertaken regarding that item. All incidences of declarations made will be recorded and maintained within the ICBs declaration registers. Any breaches with regards to the management of conflicts of interest must also be recorded and reported to the Executive Director corporate Services & Governance. Members of, and those attending, the Committee shall behave in accordance with the Constitution, Standing Orders, and Standards of Business Conduct Policy of each of the partner ICBs. Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.
Other Matters	**Review** The Committee will review its effectiveness at least annually These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Review due: November 2027

V1.5 approved by the ICB Board on xx

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board

System Primary Care Committee

Terms of Reference

Document revision history

Date Approved by Board	Version	Revision	Comment	Author / Editor
January 2022	V1.0	Initial ToRs		Ben Vinter
25.8.2022	V1.1		Revisions following first meeting of System Primary Care Committee	Christopher Leese
October 2023	V1.2		Revisions following October 2023 meeting of System Primary Care Committee	Matthew Cunningham
June 2026	V1.3		Updated TofR format, job titles following internal Management of Change and update of ICB Governance Structure	Sallyanne Hunter

Review due: November 2027

V1.3 approved by the ICB Board on xx

System Primary Care Committee

TERMS OF REFERENCE

Constitution	The System Primary Care Committee (the Committee) is established by the Board of NHS Cheshire and Merseyside Integrated Care Board ("the Board" or "ICB") as a Committee of the Board and in accordance with its Constitution, Standing Orders, Standing Financial Instructions and its Scheme of Reservation and Delegation (SORD). The Committee has been established to enable collective decision-making on review, planning, procurement, commissioning and management of primary care services in relation to primary medical services, community pharmacy, primary dental and primary (General Practice) ophthalmic services in accordance with the ICB's statutory commissioning responsibilities across Cheshire and Merseyside and its functions exercised under delegated authority from NHS England. In performing its role, the Committee will exercise its functions in accordance with the delegation agreement entered into between NHS Cheshire and Merseyside and NHS England (NHSE). [1] The Committee will also provide oversight and assurance to the Board of the effective planning and provision of primary care services across Cheshire and Merseyside. In undertaking its responsibilities, the Committee will focus on strategic oversight, assurance and decision-making relating to the commissioning, quality, performance and transformation of primary care services. The Committee shall not routinely undertake operational management activities, except where specifically required under delegated commissioning arrangements or where assurance concerns necessitate detailed oversight. The Committee will seek to maintain an appropriate balance between: • strategic development of primary care services; • assurance regarding delivery, quality, finance and performance; • statutory commissioning responsibilities; and • operational decision-making required under delegated authority. 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. The functions of the Committee are undertaken in line with NHS Cheshire and Merseyside desire to promote an increase quality, efficiency, productivity, and value for money and to remove administrative barriers. [1] https://www.cheshireandmerseyside.nhs.uk/media/cyknidfl/cm-primary-care-and-dental-delegation-agreement-2023-final-version-issued-230323.pdf
Membership	The Committee members drawn from the Board of NHS Cheshire and Merseyside shall be appointed by the Board. Committee members drawn from outside of the Board of NHS Cheshire and Merseyside shall be appointed by the Committee, in line with the approved membership outlined within the TOR. The membership shall consist of the following voting members: • at least two ICB Non-Executive Members (Chair and Deputy Chair) • at least one ICB Partner Member • ICB Executive Director of Health & Integrated Care Commissioning (or Deputy) • ICB Chief Nursing Officer and/or ICB Clinical Director • ICB Director of Finance (Primary Care, MH and AACC) • Programme Director – Neighbourhood & Community Development • Chief Pharmacist (or appropriate deputy) In attendance by invitation (non-voting): • Head of Integrated Primary Care Commissioning (Cheshire and Warrington • Head of Integrated Primary Care Commissioning (Liverpool City Region) • Associate Director of Integrated Primary Care • ICB Associate Medical Director for Primary Care & Neighbourhoods • Head of Primary Care Finance • Healthwatch nominated representative • Public Health representative • Local Medical Committee (LMC) representative • Pharmaceutical Services Regulations Committee (PSRC) representative

	• LOC (Local Optical Committee) representative • LDC (Local Dental Committee) representation • LPC (Local Pharmacy Committee) representation • Membership of other Professional Groups to be agreed/discussed further dependant on agenda item. All Committee members may appoint a deputy to represent them at meetings of the Committee. Committee members should inform the Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of clinical members). The Committee may also request attendance by appropriate individuals to present agenda items and/or advise the Committee on particular issues. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference. If the Chair or Deputy Chair, is unable to attend a meeting, they may designate an alternative ICB member to act as Chair. If the Chair is unable to chair an item of business due to a conflict of interest, another member of the committee will be asked to chair that item.
Attendance	The Committee will normally meet in private. However, where there is a requirement to undertake patient consultation in public, this will be taken into consideration when determining whether a meeting, or part of a meeting, should be held in public. Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee. Meetings of the Committee may, with the Chair's approval, also be attended by other individuals who are not committee members, for all or part of the meeting, where appropriate. 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.

	The Committee shall be supported with a secretariat function. Duties will include: • ensuring the agenda and papers are distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Director lead • ensure records of declarations of interest are maintained and made available to the Chair • ensure good quality minutes are taken in accordance with the ICBs standing orders and Corporate Standards Manual and agreed with the Chair • ensure minutes of the meeting will be circulated to all Committee members within 7 working days of the meeting, highlighting actions to be undertaken by individual members • keep a record of matters arising, action points and issues to be carried forward • keep a record of the decisions made under the authority of the Committee or made at Committee meetings • The Committee will promote the use of digital solutions, standardised reporting and continuous improvement approaches to support efficient governance and maximise the value derived from committee business.
Quorum	A meeting of the Committee is quorate if the following are present: • at least four Committee members in total, including; • at least one ICB Non-Executive Member or ICB Partner Member • at least one Clinically qualified Member • at least two ICB Directors (or their nominated deputies). 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 an alternative suitably experienced ICB Non-Executive Member will be asked Chair the meeting. 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.

Frequency/ Duration	The Committee will normally meet up to six times each year and arrangements and notice for calling meetings are set out in the ICB Standing Orders. Additional meetings may take place as required. The Board, ICB Chair, Committee Chair, or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want advice. In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.
Authority	The Committee will work collaboratively with other Board committees and governance groups to ensure clear accountability and avoid duplication. Attention will be given to maintaining clarity of responsibility between the System Primary Care Committee and: • Quality and Performance Committee; • Finance, Investment and Contracting Committee; • Neighbourhood Health Committee (or successor arrangements); • Locality-based governance structures; • Liverpool City Region and Cheshire & Warrington Primary Care Sub-Committees. The Board of the ICB has delegated authority to the Committee as set out in these Terms of Reference and the ICB SORD, and which may be amended from time to time. Delegations are in line with the ICBs functions within the ICB Constitution and NHS Act 2006 (Annex One) and its delegated functions from NHSE (Annex Two). The Committee is also subject to any directions made by NHSE or by the Secretary of State for Health and Social Care. The 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 • establish sub-committees in order to undertake any of the functions of the Committee were considered appropriate and/or necessary by the Committee. The Committee has the authority to agree the Terms of Reference of these sub-committees, including approving any decision-making authority that is normally reserved to the Committee and that can be delegated to and undertaken by the sub-committee and its members, in accordance with the ICB's constitution, standing orders, standing financial instructions, SORD and OSORD. This authority will be outlined within a decision-making matrix, approved by and overseen by the Committee. Decisions undertaken by these sub- committees will be reported back to the Committee • approve named positions within the ICB with the delegated authority to undertake any of the functions of the Committee were considered appropriate and/or necessary by the Committee, in accordance with the ICB's constitution, standing orders, standing financial instructions, SORD and OSORD. This authority will be outlined within a decision-making matrix, approved by and overseen by the Committee. Decisions undertaken by these individuals for and on behalf of the Committee will be reported back to the Committee • establish task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee. The Committee shall determine the membership and terms of reference of any such task and finish sub-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, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference The Committee provides a report on its activities with financial consequences to the next appropriate FICC to support triangulation. Decision-making and voting: Decisions will be taken in accordance with the Standing Orders and within the authority as delegated to the Committee, and as outlined within the ICBs SORD and Standing Financial Instructions. The Committee will ordinarily make decisions by consensus. Where this is not possible, the Chair may call a vote.

	Only voting members, as identified in the "Membership" section of these terms of reference, may cast a vote. Each member is allowed one vote and a majority will be conclusive on any matter. A person attending a meeting as a deputy of a Committee member shall have the same right to vote as the Committee member they are representing. In accordance with ICB policy, no member (or deputy) with a conflict of interest in an item of business will be allowed to vote on that item. Where there is a split vote, with no clear majority, the Chair will have the casting vote. 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.
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. In carrying out its role, the Committee will work alongside any of its established sub-committees where decision making authority has been delegated. These sub-committees will also provide regular reports to the Committee outlining what activity and decision have been undertaken. The Committee will provide regular assurance updates to the Board in relation to activities and items within its remit, as well as provide the Board with any items for escalation. Commissioning of Primary (GP) Medical Services: The Committee shall approve decisions on the review, planning, procurement, commissioning and management of primary medical (GP) services, subject to any decision-making authority that is delegated by the Committee to sub-committees. The Committee shall establish two sub-committees across the nine

	local authority footprints of Cheshire and Merseyside: the Liverpool City Region Primary Care Sub Committee and the Cheshire & Warrington Primary Care Sub Committee. These sub-committees will undertake any functions, responsibilities and decisions of the Committee relating to primary medical care services considered appropriate and/or necessary to be exercised at a local level. The Committee will agree the Terms of Reference of these sub-committees, including approval of any delegated decision-making authority. Such decision-making authority will be set out within a decision-making matrix approved by, and subject to oversight from, the Committee. The Committee shall oversee, coordinate and promote alignment of the functions exercised through the Liverpool City Region Primary Care Sub Committee and the Cheshire & Warrington Primary Care Sub Committee across the nine local authority footprints of Cheshire and Merseyside relating to the commissioning of primary medical (GP) services (the ICB's statutory functions under the NHS Act 2006 and the functions delegated from NHS England). This includes the following: • Develop a system-wide Primary Care Strategy including implementing the GP Forward View, or successor, through robust contractual arrangements with general practices and appropriate developmental support. • Review and consider the aggregate position of agreed service specifications and contractual proposals for all NHS C&M commissioned services from primary care providers • Develop outline framework/ expectations in regard to GMS, PMS and APMS contracts (including the oversight and monitoring of contracts, approving material contractual action such as removing a contract) • Oversee the system obligations in relation to the Delegation Agreement with NHS England and the Policy and Guidance Manual and other-directed enhanced service type national regulatory frameworks as centrally mandated. • Oversee the strategic direction for newly designed enhanced services and agree new specifications where appropriate • Performance monitoring, oversight and assurance on agreed schemes and services, and compliance to NHSE; escalating issues on to NHSE in line with first level Delegation • Making recommendations related to alignment of decisions on 'discretionary' payment in • Local Authority Footprint (e.g., returner/retainer schemes). • Co-ordinate a common approach to the commissioning, contracting and delivery of primary care services • Manage the overall budget for commissioning of primary care services, including delegated rents and rates in line with Premises

	Directions. • Overseeing delivery of national primary medical services policy at system level and ensuring compliance at place level. Commissioning of Community Pharmacy. The Committee shall: • Develop outline framework/ expectations in regard to Community Pharmacy, essential, advanced and national enhanced services, including associated budgets, quality assurance and all existing NHSEI functions. • Develop and agree local discretionary/ non-core schemes. • Oversee national Community Pharmacy policy at system / local level. • Maintain oversight of the arrangement for pharmaceutical services commissioning, including receiving assurance on the work and decisions of the Pharmaceutical Services Regulations Committee (PSRC) where appropriate. Commissioning of Dental Services. The Committee shall: • Develop outline framework/ expectations regarding the national general dental, community, personal dental and orthodontic contracting, overseeing the central contracting function is discharged in line with the Dental Policy Book and national rules/frameworks • Responsible for overseeing national dental policy at ICB system and local level • Develop and agree local improvement schemes to support delivery of the national contract and policy asks. Commissioning of Optometry. The Committee shall: • Develop outline framework/ expectations regarding the national general ophthalmic services (GOS) contractual regulations and policy • Responsible for overseeing national GOS policy at ICB system and local level • Develop and agree local improvement schemes to support delivery of the national contract and policy asks. Additional responsibilities. The Committees additional responsibilities include: • Support Primary Care development across Cheshire & Merseyside including oversight of: • Primary care networks (PCNs) ongoing development as the foundations of out-of-hospital care and building blocks of place-based partnerships • Workforce, resilience and sustainability • Maximisation of GP Contract opportunities such as ARRS (Additional roles) and QOF outcomes • Plan, including needs assessment, for primary care services across Cheshire & Merseyside and to support planning at scale for

	primary care • Have oversight of the development of an integrated Estates programme across Cheshire & Merseyside and at local level using flexibilities available through PCN arrangements, mixed estates with other partners, premises improvement grants and capital investment monies • To consolidate risk reviews of primary care services, aggregating findings and supporting solutions/ mitigations. • The Committee shall receive and review assurance relating to the quality and safety of primary care services, including information provided by the Quality and Performance Committee and other governance forums. • The Committee shall ensure there is clear oversight of quality risks relevant to primary care commissioning and shall escalate significant concerns to the Board where required. • To ensure contract proposals achieve health improvement and value for money • To oversee quality and safety of services delivered in primary care receiving regular reports from the ICB Quality and Performance Committee and Finance, Investment and Contracting Committee providing updates and assurance on primary care related quality, finance and performance issues • Ensure that conflicts of interest have been mitigated in line with the NHS C&M Conflicts of Interest Policy, and all actions/ decisions involving consultation with Committee members or GPs will record any declarations of interest. • Ratifying time limited recommendations made by the through locality specific decision making relating to this committee's remit or determining to 'call-in' such a recommendation and provide an alternative course of action. Risk Management. The Committee will also ensure the appropriate management of risks in relation to primary care; receiving regular reporting of primary care related Corporate Risks, and relevant Board Assurance Framework (BAF) risk – these will include reference to relevant sub-committee Delivery Assurance risks – both strategic and corporate as per NHS C&M Risk Management Strategy.
Reporting	The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities. The Chair will provide assurance reports to the Board at the subsequent meeting of the Board following a meeting of the Committee and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

	Confirmed minutes of the Committee will be made available to the Board. The Committee Chair will ensure that there is an annual review of the effectiveness of the Committee, with key findings and improvements report as part of Committee Annual Report. The Committee will provide a key issues report to the Liverpool City Region Primary Care Sub Committee and the Cheshire & Warrington Primary Care Sub Committee and will receive a corresponding report from each sub-committee. The Committee will provide the Board with an Annual Report timed where possible to support finalisation of the ICB Annual Report and Accounts. The report will summarise its conclusions from the work it has done during the year. The outputs of the group may be reported to NHSE/supporting assurance, awareness and interaction.
Conduct	Members of the Committee will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and any other relevant organisational policies. Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life). Committee Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB. Members are expected to actively contribute to discussion, scrutiny and constructive challenge and to prepare adequately for meetings through review of papers in advance. Members should refer to and act consistently with the ICBs Conflicts of Interest Policy and NHS England guidance: Managing Conflicts of Interest in the NHS: Guidance for staff and organisations. Where any member or regular attendee of the Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Committee, that individual must raise this with the Chair of the meeting (in advance where possible to do so) or at the meeting before the agenda item is considered. The Chair will look

	to determine whether or not that individual participates in the meeting (or part of the meeting) in which the relevant matter is discussed, either by participating in discussion or by voting. A Committee Member or regular participant who is materially conflicted may secure that their appointed substitute attends the meeting (or part of meeting) in the place of that individual if it is to either support quoracy arrangements or the discussion to be undertaken regarding that item. All incidences of declarations made will be recorded and maintained within the ICBs declaration registers. Any breaches with regards to the management of conflicts of interest must also be recorded and reported to the Executive Director corporate Services & Governance. Members of, and those attending, the Committee shall behave in accordance with the Constitution, Standing Orders, and Standards of Business Conduct Policy of each of the partner ICBs. Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.
Other Matters	**Review** The Committee will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Review due: November 2027

V1.3 approved by the ICB Board on xx

Annex One: Statutory Framework

The Health and Care Act 2022 amends the NHS Act 2006 by inserting the following provisions:

13YB Directions in respect of functions relating to provision of services

(1) NHS England may by direction provide for any of its relevant functions to be exercised by one or more integrated care boards.

(2) In this section "relevant function" means—

(a) any function of NHS England under section 3B(1) (commissioning functions);

(b) any function of NHS England, not within paragraph (a), that relates to the provision of—

(i) primary medical services,

(ii) primary dental services,

(iii) primary ophthalmic services, or

(iv) services that may be provided as pharmaceutical services, or as local pharmaceutical services, under Part 7;

(c) any function of NHS England by virtue of section 7A or 7B (exercise of Secretary of State's public health functions);

(d) any other functions of NHS England so far as exercisable in connection with any functions within paragraphs (a) to (c).

82B Duty of integrated care boards to arrange primary medical services

(1) Each integrated care board must exercise its powers so as to secure the provision of primary medical services to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility.

(2) For the purposes of this section an integrated care board has responsibility for— (a) the group of people for whom it has core responsibility (see section 14Z31), and (b) such other people as may be prescribed (whether generally or in relation to a prescribed service).

In exercising its functions, NHS C&M must comply with the statutory duties set out in NHS Act, as amended by the Health and Care Act 2022, including:

Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 1989 and section 14Z32 of the 2009 Act);
Exercising its functions effectively, efficiently, and economically (section 14Z33 of the 2006 Act);

- section 14Z34 (improvement in quality of services),
- section 14Z35 (reducing inequalities),
- section 14Z38 (obtaining appropriate advice),
- section 14Z40 (duty in respect of research),
- section 14Z43 (duty to have regard to effect of decisions)
- section 14Z44 (public involvement and consultation),
- sections 223GB to 223N (financial duties), and
- section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

In addition, NHS C&M will follow the Procurement, Patient Choice and Competition (no2) Regulations 2013 and any subsequent procurement legislation that applies to the ICB.

Annex Two: Schedule 1 – Delegated Functions

A. Decisions in relation to the commissioning, procurement, and management of Primary Medical Services Contracts, including but not limited to the following activities:
   - decisions in relation to Enhanced Services
   - decisions in relation to Local Incentive Schemes (including the design of such schemes)
   - decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices
   - decisions about 'discretionary' payments
   - decisions about commissioning urgent care (including home visits as required) for out of area registered patients.

B. The approval of practice mergers
C. Planning primary medical care services in the Area, including carrying out needs assessments
D. Undertaking reviews of primary medical care services in the Area
E. Decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions, and liaison with the CQC where the CQC has reported non- compliance with standards (but excluding any decisions in relation to the performers list)
F. Management of the Delegated Funds in the Area
G. Premises Costs Directions functions
H. Co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
I. Such other ancillary activities as are necessary in order to exercise the Delegated Functions.

SCHEDULE 2 – RESERVED FUNCTIONS OF NHSE

A. Management of the national performers list
B. Management of the revalidation and appraisal process
C. Administration of payments in circumstances where a performer is suspended and related performers list management activities
D. Capital Expenditure functions
E. Public Health Section 7A functions under the NHS Act
F. Functions in relation to complaints management
G. Decisions in relation to the Prime Minister's Challenge Fund; and
H. Such other ancillary activities that are necessary in order to exercise the Reserved Functions.

NHS
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NHS Cheshire and Merseyside Integrated Care Board

Quality and Performance Committee

Terms of Reference

Document revision history

Date Approved by Board	Version	Revision	Comment	Author / Editor
13.04.22	0.1	ICB Quality Committee	Initial Draft	Michelle Creed
11.05.22	0.2	ICB Quality Committee	Revision consultation comments	Michelle Creed
18.05.22	0.3	ICB Quality Committee	Revision consultation comments	Ben Vinter
07.06.22	0.4	ICB Quality & Performance Committee	Revision to include Quality & Performance	Ben Vinter
09.06.22	0.5	ICB Quality & Performance Committee	Revision consultation comments	Michelle Creed
31.07.23	0.6	ICB Quality & Performance Committee	Revision consultation comments	Kerry Lloyd
12.09.24	0.7	ICB Quality & Performance Committee	Revision consultation comments	Kerry Lloyd
12.09.24	0.8	ICB Quality & Performance Committee	Revision post QPC review	Kerry Lloyd
26.09.24	0.9	ICB Quality & Performance Committee	Revision post QPC review	Tony Foy
05.06.26	1.0	Updated format of the terms of reference, and updated membership in line with ICB management of change		Sallyanne Hunter Ben Vinter
08.09.26	1.1	Updates following Q&P committee	Revision consultation comments	Sallyanne Hunter Tony Foy

Review due: November 2027

V1.1 approved by the ICB Board on xx

Quality and Performance Committee

TERMS OF REFERENCE

Constitution	The Quality and Performance Committee (the Committee) is established by NHS Cheshire and Merseyside Integrated Care Board ("Board" or "ICB") as a Committee of the Board in accordance with its Constitution and in line with its Scheme of Reservation and Delegation (SORD) and Operational SORD (OSORD) The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB. The Committee's primary role is to provide strategic assurance to the Board on quality, safety, performance and health inequalities, focusing on principle risks, delivery of strategic objectives and matters escalated through the Board Assurance Framework.
Membership	The Committee members shall be appointed by the Board in accordance with the ICB Constitution. Membership of the Committee may be drawn from the ICB Board membership; the ICB' executive leadership team; officers of the ICB; members or officers of other bodies in the wider health and social care system; other individuals/ representatives as deemed appropriate. The Committee members shall be: • Non-Executive Member of the ICB (Chair) • Non-Executive Member of the ICB (Deputy Chair) • Executive Clinical Director • Chief Nursing Officer • Director of System Quality Governance & Patient Safety Specialist • Executive Director of Health & Integrated Care Commissioning or nominated deputy. • Director of Planning, Performance and oversight • Up to two ICB Partner Members Regular Attendees: • Healthwatch • Director/s of Integrated Nursing & Quality • Chief Pharmacist All Committee members may appoint a deputy to represent them at meetings of the Committee. Committee members should inform the Committee Chair of their intention to nominate a deputy to

	attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of clinical members). The Committee may also request attendance by appropriate individuals to present agenda items and/or advise the Committee on issues. The Committee shall be chaired by a Non-Executive Member of the ICB. The Deputy Chair shall be a Member of the ICB. If the Chair, or Deputy Chair, is unable to attend a meeting, they may designate an alternative ICB member to act as Chair. If the Chair is unable to chair an item of business due to a conflict of interest, another member of the committee will be asked to chair that item.
Attendance	The Committee will hold its meetings in private. Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee. 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 matters. Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary. The Committee is updated on pertinent issues/ areas of interest/ policy developments; and action points are taken forward between meetings. **The Committee shall be supported with a secretariat function. Duties will include:** • ensuring the agenda and papers are distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Director lead • ensure records of declarations of interest are maintained and made available to the Chair • ensure good quality minutes are taken in accordance with the ICBs standing orders and Corporate Standards Manual and agreed with the Chair • ensure minutes of the meeting will be circulated to all Committee members within 7 working days of the meeting, highlighting actions to be undertaken by individual members

	• keep a record of matters arising, action points and issues to be carried forward • keep a record of the decisions made under the authority of the Committee or made at Committee meetings
Quorum	A meeting of the Committee is quorate if 50% of the membership (5) are present, to include at least 1 clinical member and 1 non-executive member. 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 an alternative suitably experienced ICB Non-Executive Member will be asked Chair the meeting. 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 on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. 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.
Frequency/ Duration	The Committee will generally meet monthly and arrangements and notice for calling meetings are set out in the Standing Orders. The Board, Chair or Chief Executive may ask the 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.
Authority	The Committee is established by the ICB as a Committee of the Board. Decisions will be taken in accordance with the Standing Orders of the ICB and within the authority as delegated to the either the Committee or individual members of the Committee. Where decisions to be made are under the delegated authority of the Committee, the Committee will ordinarily reach conclusions by consensus. The Committee is authorised by the Board to: • Request further investigation or assurance on any area within its remit • Obtain such internal information as is necessary and

expedient to the fulfil its functions

- Undertake, where necessary, 'deep dives' into specific issues that will enable it to gain a greater level of understanding and assurance into specific issues that fall within its remit
- Bring matters to the attention of other committees to investigate or seek assurance where they fall within the remit of that committee
- Make recommendations to the ICB
- Escalate issues to the ICB
- Produce an annual work plan to discharge its responsibilities, ensuring the work programme is aligned to the Board Assurance Framework, strategic priorities and areas of highest risk.
- Approve the terms of reference of any sub-groups to the committee (e.g. System Quality Groups, Infection Prevention and Control, Local Maternity and Neonatal System, SEND Partnership Boards)
- Delegate responsibility for specific aspects of its duties to sub-groups. The terms of reference of any sub-groups shall be approved by the Committee.

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

Decision-making and voting
Decisions should be taken in accordance with the Standing Orders.

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

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

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

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

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

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.
Duties	The Quality and Performance Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centred, well-led, sustainable and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2022. This includes reducing inequalities in the quality of care, coupled with a focus on performance. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care. The committee will focus on quality, performance data and information and consider the levels of assurance that the ICB can take from performance oversight arrangements within the ICS and actions to address any performance issues. In undertaking its work, the committee will focus on receiving assurance regarding the effectiveness of arrangements rather than managing operational performance issues, except where these present a significant strategic risk. The Committee will receive assurance from, and provide assurance to, relevant ICB committees, sub-committees and system groups to ensure effective oversight, minimise duplication and support joined-up consideration of quality, performance, finance, workforce and strategic risks. **Quality** • Ensure that there are robust processes in place for the effective management and consideration of quality, safety, and patient experience. • Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern • Oversee development of the ICB's key quality priorities, including priorities to address variation/ inequalities in care, and recommend these priorities to the ICB for inclusion in the ICB Strategy / Annual Plan • Oversee and monitor delivery of the ICB key statutory requirements • Review and monitor quality and performance risks on the Board Assurance Framework and Corporate Risk Register, ensuring assurance gaps, control weaknesses and mitigating actions are identified and escalated to the Board

	where required. Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) • Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSEI and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained • Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites • Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programs • Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place • Ensure processes are in place to enable the ICB to identify lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded • Ensure that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD reports) • Ensure that mechanisms are in place to systematically and effectively involve people that use services as equal partners in quality activities • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people using commissioned services • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety • Receive assurance regarding the quality and safety of primary care services commissioned or delegated to the ICB, including any significant quality risks and improvement actions. **Performance** • Receive, review, and scrutinise the integrated performance reports for the ICB with a focus on quality, safety, patient experience and outcomes.

	• Ensure that contract quality performance is monitored in a way that is proportionate to risk. • Identify and scrutinise significant variations from plan of all Key Performance Indicators (KPIs). • Scrutinise the appropriateness and robustness of any management actions to address identified performance issues in relation to the quality of services. • Benchmark recovery plans against trajectories. • Agree which of the underperforming contracts need to be brought to the attention of the ICB. • Ensure the implementation of the priorities set out in the Operational Planning Guidance. • Oversee the ongoing delivery of procurements and any major service change, with a focus on quality, safety and patient experience in line with statutory requirements. • In relation to quality of services, seek assurance that the procurement of services is consistent with relevant laws and that conflicts of interest have been declared, managed and published as required. • Seek assurance that performance reports are concise, exception based and focused on risks, trends, recovery trajectories and areas requiring Committee intervention. In particular, the Committee will provide assurance to the ICB on the delivery of the following statutory duties: • Duties in relation children including safeguarding, promoting welfare, SEND (including the Children Acts 1989 and 2004, and the Children and Families Act 2014); Working Together to Safeguard Children (2023) and; • Adult safeguarding and carers (the Care Act 2014). To deliver this, the responsibilities of the Committee will include: Ensuring the ICB is informed in a timely manner of significant risks, issues and mitigation plans relating to quality and performance (in line with the remit of the Committee).
Reporting	The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities. The Chair will provide assurance reports to the Board at the subsequent meeting of the Board following a meeting of the Committee and shall draw to the attention of the Board any issues that require disclosure to the Board or require action. Confirmed minutes of the Committee will be made available to the Board. The Committee will provide the Board with an Annual Report timed where possible to support finalisation of the ICB Annual Report and Accounts. The report will summarise its conclusions from the work it has done during the year.

Conduct	Members of the Committee will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and any other relevant organisational policies. Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life). Committee Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB. Members are expected to actively contribute to discussion, scrutiny and constructive challenge and to prepare adequately for meetings through review of papers in advance. Members should refer to and act consistently with the ICBs Conflicts of Interest Policy and NHS England guidance: Managing Conflicts of Interest in the NHS: Guidance for staff and organisations. Where any member or regular attendee of the Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Committee, that individual must raise this with the Chair of the meeting (in advance where possible to do so) or at the meeting before the agenda item is considered. The Chair will look to determine whether or not that individual participates in the meeting (or part of the meeting) in which the relevant matter is discussed, either by participating in discussion or by voting. A Committee Member or regular participant who is materially conflicted may secure that their appointed substitute attend the meeting (or part of meeting) in the place of that individual if it is to either support quoracy arrangements or the discussion to be undertaken regarding that item. All incidences of declarations made will be recorded and maintained within the ICBs declaration registers. Any breaches with regards to the management of conflicts of interest must also be recorded and reported to the Executive Director corporate Services & Governance. Members of, and those attending, the Committee shall behave in accordance with the Constitution, Standing Orders, and Standards of Business Conduct Policy of each of the partner ICBs. Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make. As well as complying with requirements around declaring and managing potential conflicts of interest, Committee members

	should: • Attend meetings, having read all papers beforehand; • Arrange an appropriate deputy to attend on their behalf, if necessary; • Act as 'champions', disseminating information and good practice as appropriate; • Comply with the ICBs' administrative arrangements to support the Committee around identifying agenda items for discussion, the submission of reports etc. Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.
Other Matters	**Review of Terms of Reference** The Committee will review its effectiveness at least annually. The Terms of Reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Review due: November 2027

V1.1 approved by the ICB Board on xx

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board

Finance, Investment and Contracting Committee

Terms of Reference

Document revision history

Date Approved by Board	Version	Revision	Comment	Author / Editor
October 2022	1.0	Initial		Mark Bakewell
Feb 2023	1.1			Matthew Cunningham
Sept 2025	1.2		Amendments to responsibilities around workforce, updates around	Matthew Cunningham
Feb 2026	1.3		Establish FICC principles and wider ICB alignment	Erica Saunders (on behalf of the Chair) & Ben Vinter
June 2026	1.4		Updated Job Titles following Management of Change, and annual effectiveness review	Sallyanne Hunter

Review due: November 2027

V1.4 approved by the ICB Board on xx

Finance, Investment and Contracting Committee

TERMS OF REFERENCE

Constitution	The Finance, Investment and Contracting Committee (the Committee) is established by NHS Cheshire and Merseyside Integrated Care Board ("the Board" or "ICB") as a Committee of the Board in accordance with its Constitution and in line with its Scheme of Reservation and Delegation (SORD) and Operational SORD (OSORD).
Membership	Non-Executive Directors x 3 [one of whom shall be the Chair and must have a professional finance background] Executive Director of Finance and Contracting Executive Director of Strategy and Transformation Executive Director of Health and Integrated Care Commissioning Executive Clinical Director Executive Director of Corporate Services and Governance
Attendance	The following would be expected to attend each meeting: Corporate Director of Finance & Contracting Director of Digital Innovation & System CDIO Specialised commissioning representative The following would attend as required by the agenda: All other Executive Directors Other persons by invitation The Committee shall be supported with a secretariat function. Duties will include: • ensuring the agenda and papers are distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Director lead • ensure records of declarations of interest are maintained and made available to the Chair • ensure good quality minutes are taken in accordance with the ICBs standing orders and Corporate Standards Manual and agreed with the Chair • ensure minutes of the meeting will be circulated to all Committee members within 7 working days of the meeting, highlighting actions to be undertaken by individual members • keep a record of matters arising, action points and issues to be carried forward • keep a record of the decisions made under the authority of the Committee or made at Committee meetings
Quorum	Chair or nominated deputy, one other NED, two Executive Directors one of whom must be the Executive Director of Finance and Contracting or their designated Deputy.
Frequency/ Duration	Meetings of the Committee shall normally take place on a monthly basis and the Committee will meet not less than 10 times per year.

Authority	The Committee will operate under broad powers to scrutinise the development and delivery of annual budgets, operational and joint financial plans, to oversee financial management, investment / disinvestment and contracting arrangements, in order to provide assurance to the Board that delivery in these areas supports the ICB's strategic aims and commissioning intentions. In doing so the Committee may investigate and approve any activity as outlined within its terms of reference The Committee is authorised to: • approve decisions within the financial limits as set out in the ICB's Scheme of Reservation and Delegation (SoRD), operational SoRD (OSoRD) and Standing Financial Instructions (SFIs). Decisions exceeding those limits will be recommended to the Board. • agree C&M joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability • agree actions on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability • seek any information within its remit from any ICB employee or member; all are directed to comply with such requests. • obtain independent professional advice as required and commission reviews/ investigations or task-and-finish sub-groups. • 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 • 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.
Duties	**Under its strategic oversight remit, the duties of the Committee are to:** **Financial Governance: Decision Making, Assurance and Oversight** • oversee a system-based approach to preparing the annual operational plan, ensuring alignment with national priorities and recommending this for approval by the Board; • oversee the development of robust joint financial plans with the ICB's partner NHS organisations and recommend these for approval by the Board; ensuring that plans clearly demonstrate the use of resources to improve outcomes and tackle health inequalities. This will include a plan to meet statutory financial duties (the system financial strategy) and a joint capital resource use plan; • scrutinise the alignment of financial plans, commissioning decisions and investment strategies with population health needs, outcomes and the reduction of inequalities. • to seek assurance on the basis and calculation of contract values with provider organisations

	• to have oversight of any nationally prescribed financial exercises that have a material impact on budgets and expenditure assure oversight of the delivery of multi-year efficiency and productivity plans, aligned to the NHS Payment Scheme (NHSPS) assumptions (e.g., general efficiency factor), and the medium-term planning framework; • seek assurance that the ICB's annual budgets are prepared within limits of available funds and recommend these for approval to the Board, including review of draft ICB annual operating plan prior to submission to Board for approval; • ensure agreed ICB strategies and operational plans are underpinned by an ap- proved sustainable financial plan, monitoring and scrutinising delivery of and performance against the approved plan; • scrutinise investments/disinvestments arising from approved strategic and operational plans, assuring a robust prioritisation framework is applied to recovery plans and commissioning intentions; • monitor and scrutinise the ICB's in-year budgetary performance, monthly forecast against plan and scrutiny of any recovery plans to address and mitigate negative variance, ensuring that required efficiencies are identified and delivered, including opportunities at system level; • ensure that robust action plans are developed in response to any material breaches or variation against plan; seek assurance that the ICB's expenditure in each financial year does not exceed the aggregate of any sums received within that financial year and that the local capital and revenue resource use for each financial year does not exceed the limits specified by NHS England; • monitor and scrutinise overarching and longer-term recovery plans including timescales, forecast savings or return on investment; • approve recovery/QIPP plans above the SoRD thresholds of other Committees or Officers and receive monthly delivery assurance; • consider and recommend the ICB's financial risk appetite and tolerances at least annually and regularly review contingency plans for managing risks to breakeven and resource limits (including ICS collective duties) following scrutiny of monthly updates on risk positions and mitigations consistent with NHS England ICB/system finance business rules; • approve arrangements for risk sharing and /or risk pooling with other organisations (for example arrangements for pooled funds with other ICBs or pooled budget arrangements under section 75 of the NHS Act 2006, or Section 65Z6 of the Health and Care Act 2022); • receive and approve key ICB financial policies and financial governance arrangements; • approve new investment business cases in line with the Committee's delegated authority as outlined within the OSoRD (H1 – up to £10million, H2 – Up to £5million); • escalate to/make recommendation to the Board on new investment business cases in line with delegated authority amounts as outlined within the OSoRD (H1 – over to £10million, H2 – over to £5million); • receive regular assurance reports on and scrutinise new investment business case decisions made by other ICB Committees and

	Officers that have been made within their delegated authority as outlined within the OSoRD; • approve the requisitioning of goods and services (Non-healthcare) in line with the delegated authority limits as set out within the OSoRD (F1 and F2 – up to £500k, F3 – up to £2million). **<u>Procurement and Contract Decisions and Monitoring</u>** • oversee activity and cost against plan (both under and over agreed thresholds), and steps to address the same, including: ➢ oversight of any proposals that will impact upon the volume or quality of services provided (where there is an impact on quality this will be referred to the Quality and Performance Committee); ➢ actions that will have a material impact upon a Provider's ability to achieve its own targets (including financial balance); ➢ assurance of how contracts are being used to monitor and improve VFM/productivity, address inequalities and contribute to social/economic development. ➢ assurance from any System Integrated Commissioning and Contracting meetings and any plans being developed to address under-performance. ➢ assuring the adherence of the ICB's procurement and contracting policy and framework. ➢ ensure robust scrutiny of provider contract performance (including NHS Trusts), maintaining a clear line of sight between contractual performance, financial delivery, quality outcomes and associated risks; • receive and approve the ICB Procurement Policy/plan(s); make procurement route decisions (from £5million), in line with the options contained within the Healthcare Provider Selection Regime (2023) Regulations (Annual Contract Value), with any novel or contentious procurement route decisions to be escalated to the Board; • make decisions to put non-Healthcare goods and services (from £5million) out to competitive procurement (total contract value) with any novel or contentious procurement route decisions to be escalated to the Board; • receive regular assurance reports on and scrutinise procurement decisions made by other ICB Committees and ICB individuals that have been made within the delegated authority as outlined within the OSoRD; • approve requests for the waiver of any procurement rules for goods and services on an exception basis. **<u>Estates and Capital</u>** • monitor plans for prioritisation of future capital resource use and development of capital funding bids; • monitor and scrutinise the progress and delivery of a system wide estates and infra- structure strategy (including Primary Care); • gain assurance that the estates and infrastructure strategy is built into ICS financial framework; • ensure there is effective oversight of future prioritisation and capital funding bids, seeking assurance from and scrutinising any decisions made by other ICB commit- tees and Officers in line with their delegated authority as outlined within the OSoRD; • review the annual Joint Capital Resource Use Plan prior to recommending approval by the ICB Board.

	Digital • seek assurance that digital investments decisions are aligned to the ICB's financial strategy, comply with the SORD/OSoRD, and deliver value for money; • scrutinise regular reports on the financial performance and outcomes of digital programmes, seek assurance on risk management and remedial actions, and escalate any concerns or investments exceeding delegated limits to the Board. **Primary Care (PC)** • seek assurance that PC investments decisions and spend are aligned to the ICB's financial strategy, comply with the SORD/OSoRD, and deliver value for money recognising the delegated responsibilities of the SPCC Committee and the discrete contracting approaches within primary care; • scrutinise regular reports on the financial decisions and outcomes of primary care programmes, seeking assurance through reporting to and triangulation at the Board that risk management and remedial actions, and escalations on any concerns or investments are taking place **Specialised commissioning** • seek assurance that specialised commissioning decisions are financially sustainable, aligned with ICB strategy and commissioning intentions, and within delegated limits; • scrutinise value for money, financial risks, and delivery outcomes through receipt of regular reporting and oversight • escalate concerns or decisions exceeding financial limits to the Board. **Risk Management** • Through oversight of the information provided to the Committee, identify related areas of strategic, operational and financial risk and report these to the Board via the Board Assurance Framework (BAF), Corporate Risk Register or other appropriate mechanisms. • Ensure that the Committee's workplan, reporting and discussions are explicitly aligned to the BAF and principal risks, including review of the adequacy of controls and assurances; • Request substantive reports, deep dives and exception reports to be submitted to the Committee to provide assurance on risk mitigation, control effectiveness and the delivery of action plans. • Adopt a risk-based approach to oversight, focusing detailed scrutiny on those areas presenting the greatest risk, highest value, greatest financial exposure or most significant impact on the delivery of the ICB's strategic objectives. • Promote consistent contract monitoring, reporting standards and risk management arrangements across providers and localities to support effective assurance.

Reporting	The Chair will provide assurance reports to the Board at the subsequent meeting of the Board following a meeting of the Committee and shall draw to the attention of the Board any issues that require disclosure to the Board or require action. The Finance, Investment and Contracting Committee will prepare and submit an annual report on its activities to the Board setting out its performance against these Terms of Reference. The committee will receive reports from the following groups/committees: 1) System Primary Care Committee 2) Financial Recovery Programme Group 3) Procurement Decisions Review Group 4) Specialised Commissioning Joint Committee
Conduct	Members of the Committee will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and any other relevant organisational policies. Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life). Committee Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB. Members are expected to actively contribute to discussion, scrutiny and constructive challenge and to prepare adequately for meetings through review of papers in advance. Members should refer to and act consistently with the ICBs Conflicts of Interest Policy and NHS England guidance: Managing Conflicts of Interest in the NHS: Guidance for staff and organisations. Where any member or regular attendee of the Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Committee, that individual must raise this with the Chair of the meeting (in advance where possible to do so) or at the meeting before the agenda item is considered. The Chair will look to determine whether or not that individual participates in the meeting (or part of the meeting) in which the relevant matter is discussed, either by participating in discussion or by voting. A Committee Member or regular participant who is materially conflicted may secure that their appointed substitute attend the meeting (or part of meeting) in the place of that individual if it is to either support quoracy arrangements or the discussion to be undertaken regarding that item. All incidences of declarations made will be recorded and maintained within the ICBs declaration registers. Any breaches with regards to the management of conflicts of interest must also be recorded and reported to the Executive Director corporate Services & Governance.

	Members of, and those attending, the Committee shall behave in accordance with the Constitution, Standing Orders, and Standards of Business Conduct Policy of each of the partner ICBs. Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.
Other Matters	The Committee will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the Terms of Reference will be submitted to the Board of each ICB for approval.

Review due: November 2027

V1.4 approved by the ICB Board on xx

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside ICB

Executive Committee

Terms of Reference

V0.2

Document revision history

Date	Version	Revision	Comment	Author / Editor
01.07.2022	0.1	Initial ToRs		Ben Vinter
Sept 2025	0.2	Updates to responsibilities around workforce, areas covered previously by the Strategy & Transformation Committee, membership and quoracy. General tidying up		Matthew Cunningham
June 2026	0.3	Fundamental review aligned to ICB MoC process and following reframing of ICB Strategic Commissioning role	Endorsed by execs and reported as direction of travel to Board in summer 2027	Ben Vinter

Review due: November 2027

V0.3 approved by the ICB Board on xx

Executive Committee

TERMS OF REFERENCE

Constitution	The Executive Committee (the Committee) is established by NHS Cheshire and Merseyside Integrated Care Board (ICB) as a Committee of the Board in accordance with its Constitution and in line with its Scheme of Reservation and Delegation (SORD) and Operational SORD (OSORD). The ICB Executive Committee is established in accordance with NHS Cheshire & Merseyside's (NHS C&M) Constitution. These terms of reference set out the membership, remit, responsibilities, and reporting arrangements of the ICB Executive Committee and shall have effect as if incorporated into the Constitution. All management functions of NHS C&M (with the exception of those delegated to individuals or to another committee of the Integrated Care Board (the Board) or reserved to the ICB as detailed in the SORD) are delegated to the ICB Executive for day-to-day management and delivery. The ICB Executive will make recommendations on delivery of strategy and commissioning plans and take day to day decisions on performance management and risk management to provide robust assurance to the Board.
Membership	The Executive Committee will consist of the members detailed below: Chief Executive (Chair) and their direct reports Notified, named deputies to support attendance, participation and quoracy is encouraged. Named deputies will count towards the quoracy of the meeting and will carry the decision making authority of the individual that they are deputising for at that meeting. **In attendance** - only members of the Committee have the right to attend Committee meetings, but the Chair may invite others to be regular standing attendees to the meeting or to attend as necessary in accordance with the business of the Committee. 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.
Attendance	The ICB Executive Committee is Chaired by the Chief Executive. In the absence of the Chief Executive the committee will be chaired by a designated deputy relevant for each occasion, as appropriate.

	The Chief Executive may appoint a standing Deputy Chair from amongst any of the Members of the Committee. That individual will carry the decision making authority of the Chair for the meetings that they are Chairing. If it is known in advance that there will be the absence of both the named Chair and named Deputy Chair for a meeting that is required to go ahead on the agreed date, then the Chair can identify a deputy for that meeting from within the remaining Members of the Committee. That individual will count towards the quoracy of the meeting and will carry the authority of the Chair for that meeting. This will only occur in exceptional circumstances as all efforts should be made to find an alternative date so as to ensure the attendance of the named Chair or Deputy.
Quorum	Quorum will be three members, which must include the Chief Executive or nominated deputy. Decisions will be taken in accordance with the Standing Orders of the ICB and within the authority as delegated to the either the Committee or individual members of the Committee. Where decisions to be made are under the delegated authority of the Committee, the Committee will ordinarily reach conclusions by consensus. It is not envisaged that voting will be ether necessary or encouraged.
Frequency/ Duration	ICB Executive meetings will be held weekly. It will be necessary for ICB Executive quoracy to be maintained for any decisions relating to QIPP and financial recovery in this instance. Meetings will not, usually, be open to the public and will have the ability to schedule meetings as either face to face or electronically. 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.
Authority	The ICB Executive will act with the authority of the C&M Integrated Care Board as outlined within its Terms of Reference and the Scheme of Reservation and Delegation, covering the scope of its remit through regular reporting, discussions, investigation and action.

Duties	The scope of ICB Executive is to support the Board in undertaking its statutory duties as NHS Cheshire & Merseyside. The Committee will fulfil its purpose by fulfilling its responsibilities: **Overarching Responsibilities**: • Ensure the effective operational management of NHS C&M, through providing effective leadership and direction to the work of the organisation. • Support NHS C&M to deliver its plans, strategies, and statutory duties. • Oversee the development and review of NHS Cheshire and Merseyside plans in response to the HCP's developed strategy, ensuing they take account of the population need, and include the engagement and collaboration of partners and the VCFSE sector • Oversee the development of NHS Cheshire and Merseyside's operational and transformational plans (our Joint Forward and Annual Delivery Plan), supporting alignment of Place priorities at an aggregate level, and engaging with partners across the wider system (including VCSE and the social care sector). • Promote robust clinical and corporate governance across the organisation. • Ensure our plans and clinical commissioning policies follow the principle of proportionate universalism with the ambition to reduce health inequalities and reduce avoidable mortality. • Support the Board in setting the vision and delivering the organisation's strategic objectives. • Oversee the development and delivery of work programmes that support the NHS Cheshire and Merseyside strategy and operational plans (our Joint Forward and Annual Delivery Plan), including oversight of areas developing joint commissioning with partner organisations (and making recommendations to the Board on their approval as required). • Provide support to the development of its nine places across Cheshire & Merseyside, and the wider Integrated Care System (ICS) and all of its parts and partner interactions. **Other responsibilities** • Provide directions (as a Category 1 responder) in the event of emergency planning. • Preparedness, and response, and ensure NHS C&M supports its Partners with system, and as appropriate, with borough wide planning and activity. • Make decisions in respect of system QIPP and financial recovery, any such decision shall be reported to the next meeting of the Board for ratification. • Act in accordance with the NHS C&M Constitution, Standing Orders, Prime Financial Policies and Scheme of Reservation & Delegation. • Oversee NHSE assurance planning and responses. • Ensure that all NHS C&M strategies/ plans are fully aligned and integrated enabling effective delivery.

	• Make recommendations on investment and significant commissioning decisions to the Board that are outside of the authority of the Committee that lead to a more financially sustainable health care system. • Oversee implementation of and make decisions on the duties of NHS Cheshire and Merseyside in relation to delegated Specialised Services including delivery of the annual plans. • Make recommendations or decisions on the review, planning and procurement of delegated services for Specialised services in Cheshire and Merseyside that are not commissioned across the North West via the North West Specialised Commissioning Joint Committee. • Link with the Primary Care Committees to ensure the system wide, population-based approach is implemented to other delegated NHS England functions. • Identify opportunities at a Cheshire and Merseyside or Supra Place footprint for the transformation and integration of services to support the delivery of effective, high quality, accessible health and care services learning from the best practice taking place within Place Partnerships. • Ensure that transformation activities promote the improvement of population health and wellbeing outcomes within our communities as well as addressing health inequalities, prioritising investment / disinvestment and ensure cost effective care is delivered, developing an evidence-based commissioning / decommissioning framework. • Oversee the development of any joint and co-commissioning arrangements with Local Authority and /or external NHS bodies and recommend to the Board for approval • Oversee programmes and plans regarding significant service reconfiguration to meet the needs of the Cheshire and Merseyside population and make recommendations to the Board on the proposals. • Take account of collaborative commissioning activities, including those of clinical networks, to consider and make recommendations to the Board as to whether they will have wider contracting/financial implications across the C&M system. • Receive updates on the progress in delivery of Cheshire and Merseyside Provider Collaboratives agreed annual delivery programmes. • Determine and approve the ICB arrangements for securing legal advice, where necessary. • Approve and implement the arrangements for action on litigation against or on behalf of the ICB. • Co-ordinate and have oversight of the ICB response to any judicial review brought against the ICB. • Co-ordinate its business with the ICS wide partners, as appropriate, on matters relevant to the partnership. • Approve, or recommend for approval (dependent on SoRD), a wide range of policies and procedures, ensuring effective implementation of all such policies.

	• Monitor the implementation of the Organisational Development Strategy.
	• Will provide support to ensure that the ICB, its committees and the ICP function optimally.
	
	Governance
	The ICB Executive will:
	
	• Commission reports and audit/surveys it deems necessary to help fulfil its obligations as authorised by the Board.
	• When a steady state has been achieved the executive will review and ratify minor policy changes, recommending to the Board for approval any new policies or policies requiring significant updates/ changes.
	• Oversee the development of key governance, assurance and risk systems; ensuring processes are in place so that NHS C&M is compliant with its statutory requirements and has sound internal control arrangements
	• Ensure appropriate arrangements in respect of information governance are in place.
	• Ensure NHS C&M is compliant with Health and Safety legislation including the Corporate Manslaughter Act and Local Security Management Services (LSMS) requirements.
	• Ensure NHS C&M is compliant with its statutory duties under the Civil Contingencies Act.
	• Promote the values of the ICB and create an organisation-wide culture, which enables clinicians, managers and staff to work, both in partnership and individually, to effectively deliver safe, high-quality and affordable services.
	• Approve and oversee the implementation of the Organisational Development Strategy, including oversight of the implementation of the People Plan and People Promise.
	• Monitor all workforce performance targets and recommend remedial action plans when performance is below target.
	• Advise the Board on compliance with its statutory duties relating to people and employment legislation and to provide the Board performance reports of KPIs relating to people and employment.
	• Consider and review workforce plans in line with management costs and making recommendations where relevant to the Board or other ICB committees where required.
	• Consider and approve human resource and organisational development policies for the ICB, incorporating any that cover:
	  ○ arrangements for discharging the statutory duties as an employer
	  ○ disciplinary arrangements for ICB employees

	○ arrangements for staff appointments (excluding matters detailed within the Constitution and the ICB Board Member Appointment Policy) ○ any other terms and conditions of services for ICB AfC employees (not within the remit of the Remuneration Committee). • Prior to seeking approval from the ICB Remuneration Committee, develop and consider the ICBs Pay Policy, including approving the terms and conditions of employment for non-AFC employees including pensions, remuneration, fees and travelling or other allowances for employees of the ICB and to other persons providing services to the ICB. **Risk** The ICB Executive will: • Promote good risk management and ensure effective corporate governance systems, robust controls and processes are embedded across the organisation that also promote effective partnership working and integration. • Develop and implement the NHS C&M Risk Management Strategy. • Oversee the arrangements for monitoring the implementation of the ICB risk management framework and processes, scrutinising and challenging risk assessment and assurances provided by the Corporate Risk Register (CRR) and Body Assurance Framework (BAF). • Have oversight of the identified risks for the Committees functions/ responsibility areas that feature on the ICB BAF and CRR, observing the requirements and processes of the ICBs Risk Management Framework, and ensuring that the Board is informed in a timely manner of any significant risks, issues and mitigation relating to functions and responsibilities within its scope. • Escalate any issues or risks for inclusion on the CRR or BAF as necessary. • Maintain a risk register for the Executive Committee.
Reporting	The outputs of the group will be reported to the Board.
Conduct	Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB. Members shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy. All members are required to make open and honest declarations of the interest at the commencement of each meeting or to notify the Chair of any actual, potential or perceived conflict in advance of the meeting. All members are required to uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

Other Matters	**Sub-groups & administration** - the ICB Executive is authorised to create sub-groups or working groups as are necessary to fulfil its responsibilities within its terms of reference. Appropriate administrative support will be provided to ensure appropriate support to the Chair in relation to the organisation and conduct of meetings. Administrative duties will include: • agreement of agendas with the Chair and attendees and collation of papers • keeping a record of minutes/ actions, key issues, matters arising and issues to be carried forward. Key action points may also be taken by any attendee, and any executive decision made in respect of Quality, Innovation, Productivity & Innovation (QIPP) or financial recovery will be submitted to the Board for ratification via an accountability report. **Emergency Powers & Urgent Decisions** - In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the team to meet virtually. Where this is not possible the most senior or appropriate decision maker may exercise their powers in line with delegations. **Format -** An agenda for each meeting will be agreed with the Chair. Calls for items supporting discussion will also be made from the membership. It is anticipated that the meeting may initially have both a business and developmental focus as it established and defines its role. Sufficient time will be allocated to items to enable full exploration of issues, constructive challenge and reflection. Advice, opinion and engagement may be sought from amongst the membership outside of the regular meetings, either as a group or on an individual basis. **Review** - The ICB Executive will review its effectiveness at least annually These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Review due: November 2027

V0.2 approved by the ICB Board on

Meeting of the Board of NHS Cheshire and Merseyside

26th November 2026

ICB Risk Management Strategy 2026

Agenda Item No: ICB/11/26/26/12

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

REPORT SUMMARY SNAPSHOT

Required Information	Details				
Responsible Executive Director	Ben Vinter, Executive Director of Corporate Services and Governance				
Report approval	**By**	Ben Vinter, Executive Director of Corporate Services and Governance			
	Date	17/11/2026			
Presented by	Ben Vinter, Executive Director of Corporate Services and Governance				
Ask of the Board	**Approval**	✓	**Decision**		
	Endorsement		**Ratification**		
	Receive assurance		**Note**		
Route to Board – where has this report been discussed	Draft Risk Management Strategy reviewed by Audit Committee on 1st Sept 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*	Risk Management Strategy 2026 has implications for all BAF risks.				
Financial Implications*	**Yes**		**No**	✓	
	If Yes:				
	Have the financial implications been reviewed by the Director of Finance	×			
	Has a budget been identified	×			
Legal Implications*	N/A				
Conflicts of Interest associated with this report	N/A				
Impact assessments undertaken*	**Equality**	×			
	Quality	×			
	Data	×			
	Sustainability	×			
Public or Clinical engagement undertaken	No public or clinical engagement undertaken in the update of the Risk Management Strategy				

ICB Risk Management Strategy 2026

1. Purpose

1.1 The purpose of this paper is to present the Board with the proposed revised ICB Risk Management Strategy 2026 for ratification.

2. Executive Summary

2.1 The Risk Management Strategy describes the ICB's risk management arrangements and assurance framework and is a key component of effective governance and internal control. The strategy was initially developed in 2022, with the current version (version 2.1) approved by the Board of NHS Cheshire and Merseyside on 28th March 2024.

2.2 Although the 2024 strategy is still within the review period for Version 2.1 (due to expire in March 2027), the changing landscape of the ICB, and significant organisational changes during 2026/27 across both governance structures and staffing accelerated the need to review and update the existing strategy to ensure it remains fit for purpose.

2.3 The 2026 Risk Management Strategy represents an evolution from a predominantly operational and place-based risk management framework to a more mature 'strategic risk management' approach. Key themes in relation to changes made include:

- Stronger alignment with the ICB's role as a strategic commissioner
- Greater focus on the Board Assurance Framework and principal risks
- Introduction of a more relevant risk appetite and assurance model
- Removal of place-based risk management arrangements in favour of a single ICB-wide framework
- Enhanced governance, escalation and assurance arrangements
- Alignment with the ICB's 2026-2031 Clinical and Strategic Commissioning Plan and population health objectives

2.4 The aim is that the revised Risk Management Strategy will support and reflect the evolving governance structure of the ICB - acting a tool that delivers its message of risk management to staff in a clear and concise manner.

2.5 The Audit Committee received a draft version of the revised Risk Management Strategy for initial review at its September 2026 meeting. Feedback gathered from Committee members following the Audit Committee meeting has been used to further strengthen the strategy.

2.6 The revised strategy aims to clarify specific accountabilities, roles, and responsibilities for risk management following a period of internal organisational change. Clarity on roles and responsibilities during (and following) change is vital in ensuring managerial and strategic risk management is maintained. It is also fundamental in ensuring that staff feel safe and supported in the delivery of their duties and that the governance framework of the ICB is maintained to provide assurance through all levels of risk management, from individual to board.

2.7 In addition to a review and update, the implementation of the Risk Management Strategy will be supported by briefings, guidance and development sessions to support those charged with the governance, leadership, and management of the ICB. The initial priority is those designated as 'senior responsible leads' and risk owners as the organisation's operating model and structures are embedded. This will be followed by a proposals for a wider training programme for all ICB staff.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **APPROVE** the revised Risk Management Strategy v3.0
- **ADOPT** the updated framework for risk management and assurance across the ICB, including the roles, responsibilities and escalation processes.
- **APPROVE** the process for identification, assessment, management and review of risks
- **IDENTIFY** any further content for inclusion

4. Reasons for Recommendations

4.1 The Risk Management Strategy has been reviewed and updated to ensure it remains aligned to the evolving role, governance arrangements and operating model of the ICB. Audit Committee endorsement of the document was obtained in September 2026, whilst recognising that the wider organisational transition and national commissioning reforms required further refinement before final submission to the Board. A summary of the more significant changes made can be found in **Appendix One**.

4.2 The revised Strategy reflects the significant changes made to organisational governance arrangements, most notably the removal of locality/place-based risk management and reporting structures. The proposed approach consolidates central oversight through corporate, committee and strategic risk arrangements, providing greater consistency in risk identification, escalation, assurance and reporting across the organisation and avoiding duplication of risk management activity.

4.3 An updated Risk Appetite Statement is included in the revised strategy (the updated statement was agreed at the Board Development session in October 2026). The Board-approved Risk Appetite Statement will enhance the ICB's ability to identify, assess and manage strategic risk - providing clearer oversight of risks reported through the Board Assurance Framework (BAF) and strengthening assurance that risk-taking is aligned to the achievement of organisational objectives.

5. Background

5.1 NHS Cheshire and Merseyside ICB approved its current Risk Management Strategy in March 2024, with a forward review date of March 2027. In view of significant changes to the national NHS operating environment, the evolving role of ICBs and the emerging NHS England 'Model ICB Blueprint', an early review has been undertaken to ensure that the organisation's risk management arrangements remain appropriate and aligned to future strategic requirements.

5.2 Since the approval of the existing strategy, the role of ICBs has continued to evolve, with increasing emphasis on strategic commissioning, stewardship of NHS resources, system leadership, delivery of population health outcomes and the reduction of health inequalities. The revised strategy reflects this direction of travel and seeks to ensure that the ICB's approach to risk management supports effective decision-making, assurance and governance as the organisation transitions towards its future operating model.

5.3 The review has also provided an opportunity to align risk management arrangements with the emerging revised governance structure of the ICB. In particular, the strategy removes references to 'Place' based risk management and reporting arrangements - reflecting the recent changes to organisational structures and responsibilities and move toward the new Model ICB Blueprint. The revised framework strengthens the distinction between strategic, corporate and operational risk management and places greater emphasis on the Board Assurance Framework as the primary mechanism for overseeing strategic risks.

5.4 Management of risks will continue through a corporate Board Assurance Framework (BAF), for risks to strategic objectives and a Corporate Risk Register (CRR), for risks identified and escalated from managerial functions. Both will continue to be supported by scrutiny and assurance via the ICB committees.

5.5 The key risk definitions and risk impact scoring describe how risks will be assessed at corporate level. Risk tolerances will drive the response and escalation at and between corporate and place levels. The strategy also sets out specific accountabilities, roles, and responsibilities for risk management.

5.6 It is recognised that the strategy may need to adapt and evolve with the organisation as its approach to risk management matures.

5.7 The proposed revised strategy includes a significant revision to the 'Consequence Score Matrix' when compared to the 2024 version. The impacts of risk are segregated into seven organisational 'domains' which are more in line with the ICB's future operating model and strategic objectives and aim to support a more consistent and proportionate assessment of impact:

- Quality and Access
- Legal and regulatory compliance
- Health outcomes and inequalities
- Workforce and organisational capability
- Financial sustainability and resource allocation
- Partnerships and social value
- Planning and transformation

5.8 The scope of the strategy comprises the corporate entity of the ICB rather than the wider partnership of the ICS. Further development of a system approach to risk management and system assurance framework may be required in conjunction with partners.

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

Objective One:	**Tackling Health Inequalities in access, outcomes and experience**
Objective Two:	**Improving Population Health and Healthcare**
Objective Three:	**Enhancing Productivity and Value for Money**
Objective Four:	**Helping to support broader social and economic development**

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

The Risk Management Strategy is a key enabling document for the delivery of the ICB's Annual Delivery Plan. It provides the governance framework through which risks to the achievement of annual objectives are identified, assessed, escalated and managed. The revised strategy strengthens the alignment between strategic objectives, delivery priorities, the Board Assurance Framework and risk reporting arrangements, supporting effective oversight, decision-making and assurance across the organisation during a period of significant organisational transition

8. Link to meeting CQC ICS Themes and Quality Statements

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

The establishment of effective risk management systems is vital to the successful management of the ICB and local NHS system and is recognised as being fundamental in ensuring good governance. As such the risk management underpins all themes, but contributes particularly to leadership, specifically QS13 – governance, management and sustainability.

9. Finance

Not applicable

10. Communication and Engagement

10.1 The Risk Management Strategy has been a functioning component of the ICB's governance since 2022. This update addresses the organisational change as the ICB transitions to a strategic commissioner.

10.2 Guidance and training – materials currently in place to support training for risk owners remain in place. This includes aligning support from governance and risk management leads to ICB committees and to risk owners within each committee domain.

10.3 External risk management training will be considered should a demand and feasibility need be identified.

11. Equality, Diversity and Inclusion

Not applicable

12. Climate Change / Sustainability

Not applicable

13. Next Steps and Responsible Person to take forward

13.1 Should the Board approve the 2026 Risk Management Strategy the proposed communication actions described in section 10 (Communication and Engagement) will be initiated.

13.2 Following feedback from the October 2026 Board Development Session, further development of the ICB's Board Assurance Framework (BAF) will be undertaken. This will include the addition of revised risk appetite statements for each principal risk and a review of risk descriptions to ensure they effectively reflect the ICB's strategic commissioning intentions and support delivery of the 2026-2031 Clinical and Strategic Commissioning Plan, including the Population

Health Improvement Plan. The updated BAF will be brought back to the Board in January 2027 following completion of this work during Quarter 3.

13.3 The 'Risk Management Hub' (accessed via the 'We Are One' Staff Hub) will be updated with the most current 'key contacts' from the Governance & Risk Team, with the overall content and 'further resources' also updated to provide staff with the necessary guidance, risk management tools and document templates to support consistent application.

13.4 To support delivery of the Risk Management Strategy, the Governance & Risk Team is exploring the procurement of an electronic Risk Management Information System (RMIS). The system would enhance risk oversight and reporting, strengthen governance and assurance processes, and provide improved visibility of risks across all organisational levels. It would also support management of the Board Assurance Framework, risk appetite monitoring and action tracking, reducing the administrative burden of manual processes.

14. Officer contact details for more information

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15. Appendices

Appendix One: Risk Management Strategy 2026 Summary of Changes
Appendix Two: Risk Management Strategy – V3

Appendix One - Risk Management Strategy 2026 Summary of Changes

Area	Summary of Change in 2026 Strategy	Rationale
Strategic Focus	Increased emphasis on the ICB's role as a strategic commissioner, system leader and steward of NHS resources, aligned to the emerging Model ICB Blueprint and 2026-2031 Clinical and Strategic Commissioning Plan.	Reflects national expectations of Integrated Care Boards and ensures risk management is aligned to delivery of long-term strategic commissioning objectives rather than solely operational oversight.
Board Assurance Framework (BAF)	Stronger integration between strategic objectives, principal risks and the BAF, positioning the BAF as the primary strategic risk management tool	Improves Board oversight of principal risks and aligns risk management arrangements to recognised governance best practice.
Risk Appetite	Introduction of an updated organisational Risk Appetite Statement with explicit appetite levels relating to patient safety, statutory compliance, innovation, transformation and financial sustainability.	Provides clearer guidance for decision-making, escalation and risk acceptance across the organisation.
Governance Arrangements	Replacement of the 'interim' Risk Committee approach with establishment of a Corporate Assurance Group (CAG) responsible for oversight of the Corporate Risk Register and risk assurance processes.	Streamlines governance arrangements and strengthens triangulation of assurance activity.
Place-Based Risk Management Arrangements	Removal of separate place-based impact scoring and adoption of a single ICB-wide consequence scoring approach.	Reflects ICB structure post-Management of Change and move to single corporate risk framework with consistent application across the ICB.
Risk Scoring Methodology	Removal of separate place-based impact scoring and adoption of a single ICB-wide consequence scoring approach.	Better reflects the strategic objectives and statutory responsibilities of a modern ICB.
Directorate Risk Registers	Introduction of defined escalation and de-escalation criteria for Directorate Risk Registers based on risk score, management capability and assurance effectiveness.	Strengthens consistency and transparency in risk escalation decisions.
Risk Escalation Framework	Revised escalation model introducing clearer distinctions between Board Assurance Framework, Corporate, Committee, Directorate and Programme/Project risks.	Improves clarity of ownership, accountability and escalation pathways.
Strategy focus and structure	Strategy rewritten to focus on assurance-led risk management, strategic commissioning, organisational objectives, stewardship and population health outcomes.	Ensures the strategy reflects the maturity of the ICB and current NHS England expectations for risk management and governance.

NHS
Cheshire and Merseyside

Risk Management Strategy – v3.0

Compassionate Inclusive Working Together Accountable

Leading integration through collaboration

Version Control

Version Number	Date	Purpose/Change	Date Ratified	Committee	Next Review Date
1.0	Sept 2022	Initial version		**Risk Committee** 6th September 2022	March 2023
1.1	Feb 2023		23rd Feb 2023		March 2024
2.1	March 2024	**Risk matrix**: Adopt single, combined impact scoring for ICB wide & place risks. Split extreme (red) category to create additional critical (black) category. Risk scoring 8 or 10 with minor (2) impact, reduced from high to moderate. **Escalation & de-escalation thresholds**: Increase threshold for escalation for Corporate Risk Register from 12+ to 15+. Increase threshold for escalation to committee risk registers from 8+ to "high." Removes risks scoring 8 or 10 with minor (2) impact scores. Unified escalation threshold for corporate and place risks – with grouping of common risks. **Review & reporting frequency**: Critical risks reviewed monthly by Senior Responsible Owners. Extreme/High risks reviewed quarterly – monthly by exception if mitigating actions are off track/ineffective. Quarterly routine reporting to ICB committees.	28th March 2024	**Audit Committee** 5th March 2024 **Board of NHS C&M** 28th March 2024	March 2027

3.0	Nov - 2026	**Risk Matrix:** Removal of place-based risk management arrangements and impact scoring matrix – replaced by single ICB-wide framework **Risk Appetite Statement**: Updated Risk Appetite Statement agreed by Board (October 2026)		**Audit Committee**	September 2027

Document Owner: Executive Director of Corporate Services and Governance	Approval date:	
	Approved by:	
	First published:	September 2022
	Where published:	ICB website & Staff Hub
	Next review date:	September 2027

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1. Introduction

NHS Cheshire and Merseyside Integrated Care Board (referred to in this strategy as "the ICB") was established as a statutory body on 1st July 2022.

Operating across nine geographical areas of Cheshire East, Cheshire West, Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington, and Wirral, the ICB forms part of the wider Cheshire & Merseyside Integrated Care System (ICS).

Working collaboratively with ICS partners, the ICB has a vision for everyone in Cheshire & Merseyside to have a great start in life and get the support they need to stay healthy and live longer.

Strategic aims

The transition from the ICS Design Framework (2021) to the new model ICB Blueprint places a greater emphasis on the ICB's role as a 'strategic commissioner', stewardship of NHS resources, system leader and accountable body for population health outcomes.

The C&M ICB Risk Management Strategy (2026) will support the transition towards the emerging Model ICB Blueprint by ensuring that the organisation identifies, assesses and manages strategic risks associated with population health improvement, health inequalities, financial sustainability, strategic commissioning, system leadership and organisational transformation. The Strategy will promote a proactive and assurance-led approach to risk management, enabling the Board to fulfil its stewardship responsibilities and maintain effective oversight of delivery against the ICB's core objectives:

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

The ICB recognises that risk management is an essential business activity that underpins the achievement of those aims.

This strategy aims to support the ICB's commitment to risk management and define the framework to which the ICB will manage risk, from strategic risks through to operational risks. It lays out a systematic and consistent framework and covenant principles for risk management, whilst aiming to enable the delivery of the strategic objectives of the ICB.

Strategic objectives

Strategic objectives, while broad in nature, should be specific enough that their achievement can be assessed, and progress measured.

The Board of the ICB will review and define its strategic objectives, annually. The objectives should describe organisational goals that help establish priority areas and define what success looks like, for staff, committee/board members, external partners,

and service users.

The ICB's strategic objectives are aligned to the Board Assurance Framework (BAF). The BAF is a key framework that is based on the ICB's delivery of its strategic objectives and is central to the Risk Management Strategy.

2. Scope

This strategy outlines the ICB's approach to risk management with the aim of providing a framework to support the delivery of the ICB's vision and mission by ensuring high-quality services are commissioned within available resources and while providing a safe working environment for staff.

This strategy sets out the framework to support the management of operational and strategic risks across the ICB, including how risk management, ownership and accountability are defined. This includes specifying the processes to identify and report new and emerging risks, along with associated risk registers to support assurance of mitigation, transfer or closure of risks.

This strategy applies to all employed staff, including board and committee members, appointees of the ICB, and any individuals within the ICB in a temporary capacity.

This strategy applies to all risks that may affect the delivery of the ICB's strategic and operational objectives, including those arising from collaboration with partner organisations and jointly hosted arrangements.

3. Definitions

Definitions of terms used in this strategy are given below:

Risk	The effect of uncertainty on objectives. Risk is the combination of the probability of an event and its consequence. The chance of something happening will have an impact on objectives. An uncertain event or set of events that, should it occur, will influence the achievement of objectives.
Issue	A relevant event that has happened or is certain to happen was not planned and requires specific management action. The distinction between an issue and a risk is that an issue is an event that has happened or will happen, and a risk is an event that may happen.

Risk Assessment	A systematic process of identifying, analysing and evaluating risks.
Impact	A measure of the anticipated effect on the achievement of NHS C&M's objectives if the event or set of events occurs.
Likelihood	A measure of the chance or probability of the event or set of events occurring.
Risk Rating	The severity assigned to a risk following assessment. This is determined by multiplying the impact of the risk by the likelihood of occurrence.
Risk Matrix	A matrix setting out the criteria used to define and measure the impact and likelihood, resulting in the risk rating. This aims to ensure a consistent approach to the rating of risks across the ICB. Impact may be measured in the context of each operational directorate or collectively across the ICB.
Risk Management	The culture, framework, processes and structures that are directed towards identifying, understanding and controlling exposure to risks which may threaten the achievement of the ICB's objectives.
Risk Register	A register of risks that threaten the achievement of ICB's objectives. It is a dynamic document, populated through the organisation's risk management process, enabling risk to be quantified and ranked. It provides a structure for collecting information about risks that helps both the analysis of risks and in decisions about whether or how these risks should be treated.
Controls	The systems or processes we currently have in place to prevent a risk from occurring, or to reduce the potential consequences and likelihood. Examples of possible controls include: • Implementation of policies and guidance • Management structure and accountabilities • Corporate and clinical governance processes • Statutory frameworks e.g., Standing Orders, Standing Financial Instructions, Scheme of Delegation • Incident reporting, complaints, and patient and public feedback procedures • Staff recruitment, retention and training.
Assurance	Confidence, based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved.
Assurance Framework	A structured means of identifying, mapping and assessing sources of assurance in relation to the strength and effectiveness of internal controls to mitigate the risks to the organisation's objectives. By receiving and reviewing actual assurances and using findings, the adequacy of internal control can be confirmed or modified.

Board Assurance Framework	A document used to capture and provide assurance to the ICB's board in relation to the control of the principal risks and delivery of the strategic objectives.
Principle Risks	The key risks, of such significance should they be realised, would prevent the ICB from delivering its strategic objectives, continuing to operate and/or seriously affect its performance or reputation. These include risks that would threaten the business model, future performance or financial sustainability of the ICB.
Corporate Risks	Risks that threaten the delivery of the ICB's operational plan, statutory functions and duties. These include risks in relation to corporate and at-scale functions.
Risk Appetite	The amount of risk that the ICB is willing to seek or accept in the pursuit of its strategic objectives. It is used by the leadership team to determine what potential options will/will not be considered in pursuing these objectives.
Risk Tolerance	The boundaries of risk taking outside of which the ICB is not prepared to venture in the pursuit of its strategic objectives. This is determined by the Board and reflected in this document. It is to be used by leadership to determine where action is required to improve control and when risks require escalation.

4. Roles and Responsibilities

The strategy applies to all staff working within NHS Cheshire and Merseyside whether employed, contracted or on a voluntary basis.

Specific accountabilities, roles and responsibilities for risk management are set out below and provide a framework that supports the integrated approach to risk and governance. The ICB's governance structure is attached as **Appendix 3**.

4.1 Responsibility of the ICB

The ICB holds overall accountability for risk management and the framework that it is managed in. The ICB will also be responsible for defining the organisational appetite for risk and the tolerance levels for which the framework will operate.

The Board will be responsible for defining and implementing the strategic direction of the organisation, delivered through the strategic objectives, roles and responsibilities as set out in the ICB's governance structure. The ICB will therefore provide oversight, resources and support systems, as required, to ensure risks are tolerated, reduced, transferred or closed as required.

To deliver this, the ICB will ensure that:

- This strategy is monitored and reviewed.
- This strategy is communicated to staff and committee/board members.
- Advice and support/training are provided to staff in relation to the application of this strategy.

The Board will determine the ICB's risk appetite in relation to the achievement of its strategic plan, which will inform strategic decisions and control efforts; and it will identify the principal risks to the organisation.

4.2 The Audit Committee

The Audit Committee provides oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.

In relation to risk management, the core responsibilities of the Committee include:

- Reviewing the adequacy and effectiveness of governance, risk management and internal control across the ICB's to support the achievement of its objectives.
- Providing oversight of principal risks, including scrutiny of key controls and assurances.
- Having oversight of corporate/managerial risks, by exception, where these are escalated for the purposes of providing assurance to the Board.

4.3 Corporate Assurance Group

The Corporate Assurance Group (CAG) will ensure that risks to the delivery of the ICB's Operating Plan, statutory duties and strategic objectives are systematically identified, recorded, owned, monitored and managed using a triangulated rage of intelligence and assurance sources.
The Group will ensure risks identified through challenge, review and assurance activities are promptly assessed and recorded on the Corporate Risk Register or escalated to the Board Assurance Framework, as appropriate. The Group will monitor and scrutinise all risks on the Corporate Risk Register on a cyclical basis an receive assurances that:

- Risks are reviewed at the agreed frequency
- Scores remain valid
- Controls and actions are delivered and effective

4.4 Responsibility of other committees/sub-committees

All committees and sub-committees of the ICB are responsible for:

- Supporting strategic objectives by providing assurance on key controls where this is identified as a requirement within the Board Assurance Framework.
- Support managerial risks, within their jurisdiction, by ensuring that risks are identified, reflected in the relevant corporate risk registers and are effectively managed.

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

Risks cannot always be addressed in isolation from each other. Where a risk may comprise different areas, e.g. finance and quality, risks may be held and scrutinised by more than one committee. In these cases, clear lead ownership must be identified to ensure accountability is maintained.

4.4 Responsibility of Individuals

4.4.1 Chief Executive

The Chief Executive of the ICB is the Accountable Officer with the responsibility for ensuring that the control systems in place to support the achievement of the ICB's vision and mission. This includes the delivery of a risk management framework in place within the ICB.

4.4.2 Executive Director of Corporate Services and Governance

This role is responsible for the development and delivery of the Risk Management Strategy and associated operational procedures.

Delivery of the following actions can be delegated, but overall accountability remains with the Executive Director of Corporate Services and Governance:

- Promoting effective risk management and demonstrating leadership, involvement and support.
- Preparing the Risk Management Strategy for review by the Audit Committee and approval by the Board.
- Ensuring the development of the Risk Management Strategy, including defining the procedures, standards and guidance to support the effective delivery of the strategy
- Supporting the Audit Committee Chair in forward planning and agenda setting in respect of risk management and ensuring that committee members are aware of best practice, national guidance and other relevant documents and have access to independent advice as appropriate.
- Responding to requests from the Audit Committee and the Board for reports and assurance on risk management arrangements
- Leading the preparation and regular updating of the Board Assurance Framework and Corporate Risk Registers for review by relevant Committees and the Board.
- Assuring the effective and consistent implementation of risk management and assurance arrangements corporately and at directorate level
- Identifying the training needs of the Board, its committees/sub-committees and staff and ensuring these needs are met.

4.4.3 Senior Responsible Officers (SRO)

SROs are members of the Senior Leadership Team and have responsibility for the oversight of the risk. They will also provide direction and management support where appropriate to the risk owner and they are accountable to the relevant Executive Lead.

4.4.4 Risk Owners

Risk owners will have responsibility for managing and reviewing their assigned risks, ensuring each identified risk has mitigating controls and assurances in place. This includes assessment, the identification and implementation of actions to mitigate the risks, and compliance with reporting arrangements such as updating the risk register, escalating risks and providing assurance to the relevant committee.

Risk owners will be accountable to the relevant SRO.

4.4.5 All ICB staff

All ICB staff are responsible for complying with the arrangements set out within this strategy and are expected to:

- Attending mandatory and statutory training.
- Co-operating with arrangements for minimising risk.
- Reviewing their areas of work to identify risks, agree appropriate actions and escalate risks as necessary.
- Consider risks when developing business cases, commencing procurements or any other activity which could be impacted by unexpected events (undertaking specific risk assessments as necessary).
- Reporting risks, incidents and near misses using the correct processes and documentation.

4.4.6 Subject Matter Experts

Expertise in specific areas of risk may be obtained from several sources, both internal and external, such as:

- Governance and Risk leads
- Health and Safety lead from commissioned providers
- Occupational Health Manager from commissioned providers
- Local Anti-Fraud Specialist (AFS)
- NHS Resolution
- Health & Safety Executive (HSE)

5. Risk Appetite

The UK Corporate Code of Governance sets out that ‘The board should establish procedures to manage risk, oversee the internal control framework, and determine the nature and extent of the principal risks the company is willing to take to achieve its long-term strategic objectives.’

As part of the annual planning process the board will carry out a robust assessment of the organisation's emerging and principal risks. This aims to identify the significant external and internal threats to the achievement of the ICB's strategic goals and continued functioning.

The ICB's updated Risk Appetite Statement (2026) can be found in **Appendix 1**.

6. Risk Management

It is accepted that it is neither realistic nor possible to eliminate all risks. It is, however, feasible to develop a systematic approach to the management of risk so that adverse consequences are minimised, or in some cases, eliminated.

The ICB is committed to maintaining proportionate and effective risk management arrangements that support a positive risk culture and informed risk-taking within agreed levels of risk appetite and tolerance.

This strategy and policy is supported by associated procedures, guidance and risk management tools and is aligned to NHS England's principles for assessing risks across integrated care systems.

The risk management process is illustrated below with each stage described in the following sections.

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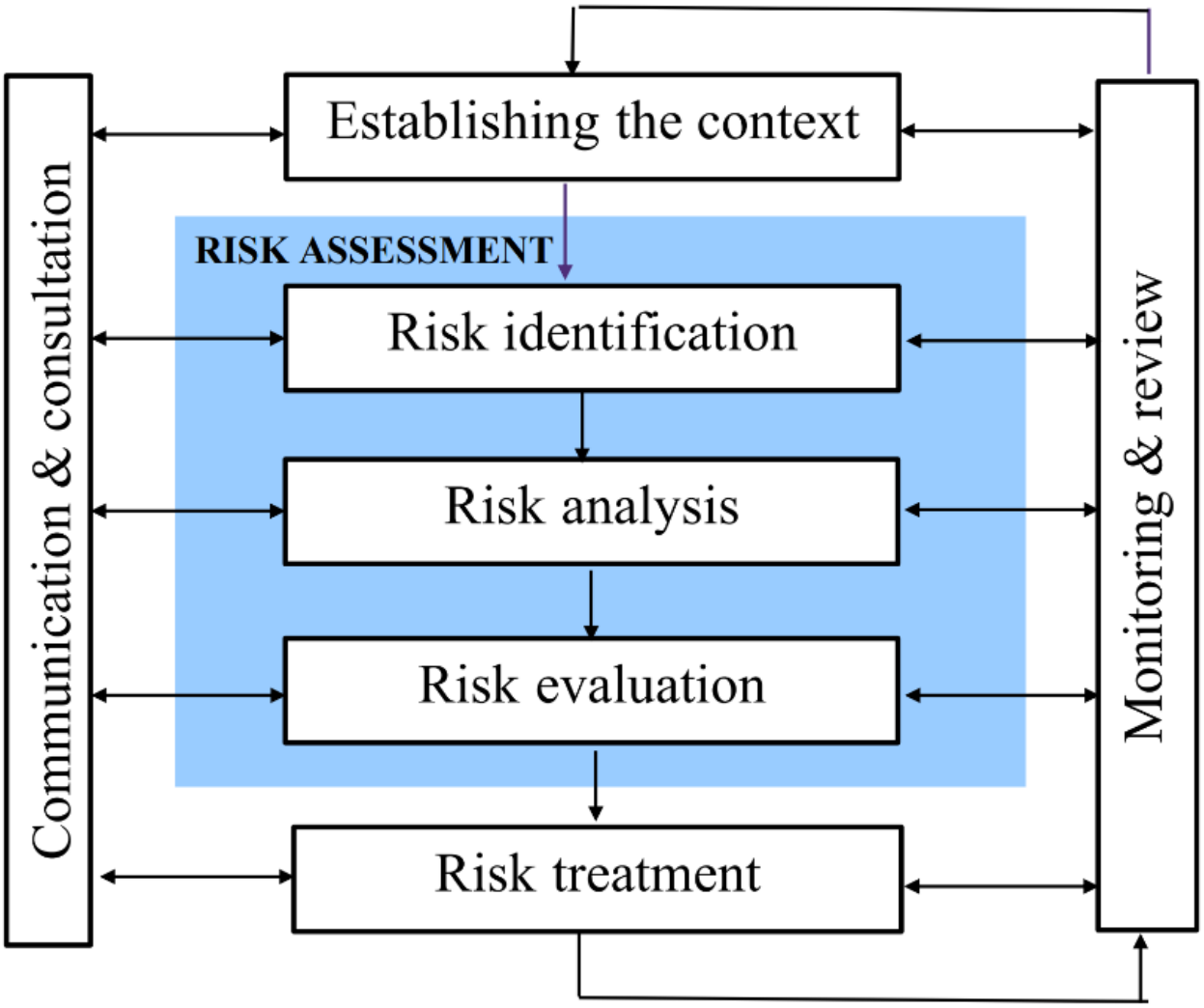

6.1 Risk Identification

The ICB is exposed to a wide range of potential risks which may threaten the achievement of the strategic objectives or delivery of statutory functions.

The ICB, through its staff, supported by the governance structure, have a key role in the identification of risks to the delivery of their day-to-day duties. Risks should be identified through a variety of methods, including audits, risk assessments, feedback from external review, incidents & complaints and team level horizon scanning.

To support staff and the delivery of the ICB's function, each meeting should have a standing agenda item to flag any new risks that may need to be considered, reviewed and escalated to the relevant committee.

6.2 Risk Analysis

The corporate risk summary will be used to analyse and record each identified risk to include:

- Risk description which should include the cause, effect and impact on the organisation
- Ownership of the risk including operational and executive leadership and overseeing committee
- Strategic objective or function that will be impacted by the risk
- Controls that are currently in place to mitigate the risk and an assessment of their effectiveness
- An evaluation of the impact and likelihood of the risk using the ICB's risk matrix at **Appendix 2** to arrive at a risk rating – both an inherent (pre-controls) rating and a current (with existing controls) rating
- Risk proximity (the estimated timeframe within which a risk event is expected to occur, assuming no further mitigating action is taken)

6.3 Risk Evaluation

The purpose of risk evaluation is to assess the severity, in the context of the ICB's risk appetite and determine the appropriate risk treatment. The evaluation considers the appetite to accept the risk following mitigation.

It should be acknowledged that it is not always possible to show continuous improvement in all risk ratings or eliminate risk completely. For those risks that cannot be removed / reduced entirely, the risks must be mitigated to a level, which the organisation is willing to tolerate. In the short term, a target score above the optimal risk appetite level may be approved by the relevant ICB Committee or the Board.

When assessing individual risks, the following questions should be considered to assist in determining whether a risk is acceptable:

- What is the level of risk currently being faced?
- What is the likely impact?
- Can we tolerate the possibility of that risk happening?
- If not, do we want or need to do more?
- Will the cost of managing this risk outweigh the benefit?

6.4 Risk Treatment

Risk treatment (also known as risk control) is the process of selecting and implementing measures to mitigate the risk to an acceptable level. Once risks have been evaluated, a decision should be made as to how they are treated. The level and type of treatment will vary depending on the level of residual risk that has been determined and the tolerance for bearing any negative outcomes that result from a risk happening.

In treating risks, the ICB may consider the following approaches:

- **Avoid**: Stop the activity. Remove the source of the risk completely.
- **Reduce** (Mitigate): Act. Lower the chance or the impact of the risk.
- **Transfer** (Share): Pass the risk to someone else. The third party accepting the risk should be aware of and agree to accept this obligation.
- **Tolerate** (Accept/Retain): Keep the risk. Do nothing if the cost to fix it is too high

Most managerial risks can be mitigated, with action taken to reduce their likelihood and/or impact in line with the ICB's risk appetite.

'High' and 'extreme' managerial risks (those scoring 15 or above) which are not deemed to be treatable will be highlighted to the Board as part of routine risk reporting.

6.5 Risk Management, Oversight and Reporting

Risk registers will be maintained for the purposes of monitoring and reporting on risks including:

Corporate Risk Register: to record all the risks which are rated as extreme or critical (15+). This will include risks to corporate and at scale objectives and functions and aggregated (in common) and unique risks to objectives and functions.

Risks will be categorised by strategic objective or, where they don't relate to the delivery of a strategic objective, by functional themes of quality, finance, performance, workforce. All risks on the Corporate Risk Register will be allocated to an ICB Committee for oversight and assurance to the Board.

Committee Risk Registers: will reflect those risks attributed to each committee which are rated as 'high', including corporate and directorate risks.

Directorate Risk Registers: to record all the risks owned by a corporate directorate. Risks will be categorised by strategic objective or, where they do not relate to the delivery of a strategic objective, by functional themes of quality, finance, performance, workforce.

Programme and Project Risk Registers: will be maintained for all corporate and directorate programmes and projects (for example, with consistent use of 'RAID' logs). Risks that cannot be managed at this level, have a significant impact on operational objectives (i.e. risks rated as high) will be escalated to the relevant Corporate Risk Register and reported to the relevant committee.

Critical risks (20+) should be **reviewed at least monthly** by the Senor Risk Owner in conjunction with the Operational Lead, with the aim of reducing the risk level as soon as possible.

Following committee approval of the mitigation strategy and target score, extreme and high risks should be reviewed quarterly by Operational Leads, or monthly by exception if mitigating actions are off track or not having the anticipated impact in reducing the risk level.

Risk owners should monitor their risks – reviewing & evaluating to:

- Confirm that action plans to address risks are being undertaken and on track or completed
- Report any change in assessment of the impact and likelihood of the risk
- Confirm that the risks are still relevant within the changing environment
- Escalate if necessary, including if the risk cannot be managed at the current level; and
- Agree mitigating action target dates and provide an explanation as to why original target dates have not been met, for strategic and principal risks, if applicable.

The review process should fulfil the following requirements. It should:

- Monitor whether controls remain aligned to risks in their area of responsibility
- Monitor whether key risks are being managed within the risk appetite or agreed tolerance in their area of responsibility
- Monitor the risk profile and key risks identified by the process and how they are changing over time
- Monitor the progress of actions to treat key risks and the operation of key controls
- Escalate issues
- Re-prioritise resources
- Make better informed decisions

Moderate and low risks should be subject to a quarterly light touch review by directorate / service / team management sufficient to confirm that the level of risk has not increased and controls remain effective.

6.6 Risk Closure

Once a risk has reached its target tolerance level/target score, and all agreed actions to control and assure have been completed, it may be recommended for closure or de-escalation to the relevant owning group, committee or board (risk level dependant) for management under ‘business as usual’ arrangements. The relevant oversight group, committee or board will have the opportunity to scrutinise the decision and provide challenge where necessary.

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Recommendations to close or de-escalate **managerial** risks will be approved by the relevant oversight group, committee or board.

Recommendations to close or de-escalate **corporate** risks will be considered at the appropriate committee, prior to a recommendation to the Board.

Where a risk on the Corporate Risk Register remains at corporate oversight level (despite all reasonable mitigations being implemented, any proposal to close the risk and formally accept the residual risk must be approved by the Board.

A more detailed summary of risk escalation / de-escalation thresholds can be found in **Appendix 4** of this Strategy.

7. Strategic Risk Management

Strategic risks are high-level threats to the achievement of the ICB's strategic objectives and statutory duties. They are proactively identified, linked to Board-approved strategic objectives, owned by Executive Team members, and managed through the Board Assurance Framework (BAF).

The BAF provides the Board with confidence that strategic risks have been identified and there are robust systems, policies and processes in place (controls) that are effective and driving the delivery of their objectives. It provides confidence and evidence to demonstrate that what needs to be happening is actually happening in practice (assurances).

The ICB's BAF aligns with the 'three lines of defence' model, where operational management (first line) manages risks day-to-day, oversight functions such as risk and governance teams (second line) provide monitoring and challenge, and internal audit (third line) provides independent assurance. This alignment ensures clear accountability and supports the Boards in making informed decisions on the management of strategic risks.

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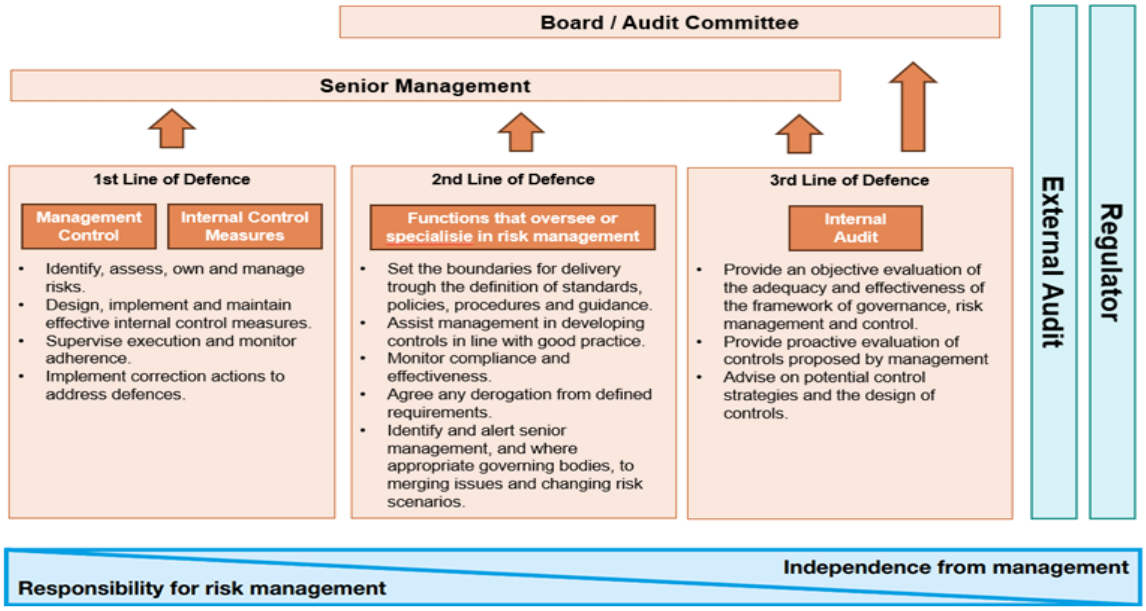

The BAF is the Board's principal tool for overseeing strategic risks and discharging its responsibility for maintaining an effective system of internal control. It supports the annual Governance Statement and provides assurance that key risks are being managed effectively. Assurance is derived from the assessment of controls and supporting evidence, providing confidence in the management of risk. While absolute assurance cannot be achieved, assurance activities help identify whether controls are operating effectively and highlight areas requiring further action or improvement.

8. Information Risks

Information risk management is overseen by the Senior Information Risk Owner (SIRO), who is accountable for ensuring information risks are identified, assessed, treated, monitored, and reported appropriately. The SIRO provides assurance that effective information governance, security, and risk management controls are in place and that the organisation complies with relevant legal, regulatory, and contractual requirements, including the Data Protection Act 2018, UK GDPR, the Human Rights Act 1998, and applicable information and cyber security standards. The SIRO also promotes a risk-aware culture and ensures that significant information risks are escalated and managed in line with the organisation's risk appetite.

Information risks may arise from the loss, misuse, unauthorised access to, or inadequate protection of information in either digital or physical form. These risks can affect the confidentiality, integrity, and availability of information and are managed through appropriate controls and governance arrangements, including Information Asset Registers, Data Flow Mapping, information governance incident management processes, and Data Protection Impact Assessments (DPIAs).

9. Management of Issues

The distinction between risks and issues is fundamental to effective risk management. As described throughout this document, a risk is a potential future event or circumstance that could impact the achievement of organisational objectives, whereas an issue is an event that has already occurred and requires immediate management and resolution. Failure to differentiate between the two can result in risks not being proactively managed - or issues not being addressed promptly. Clear identification enables appropriate escalation, ownership, reporting, and assurance arrangements, supporting informed decision-making and the effective allocation of resources.

Known issues are an important mechanism to determine if there are any new risks to be identified and captured within the risk management arrangements.

10. Monitoring and Review

It is essential that the ICB is properly informed about risk and is able provide evidence that it has identified its objectives systematically, managed the principal risks to achieving those objectives through systems of internal control and obtained assurances of effective risk management arrangements are embedded. The Board Assurance Framework and Corporate Risk Registers are designed to fulfil this purpose.

Through a process of audit and monitoring the ICB will undertake a review of the risk control measures regularly; using the following risk control and monitoring measures:

- Regular review of the BAF
- Ongoing review of the Corporate Risk Register
- Annual review of the Risk Management Strategy
- Audits undertaken by internal and external auditors
- Aggregated statistical and trend reporting of incidents, complaints and claims to the Board and relevant committees
- Ongoing audit of implementation of the range of risk management policies, procedures and guidelines throughout the organisation

10.1 Communication

Consideration should be given as to who needs to be informed of the risk. Consideration should also be given as to whether any external stakeholders should also be informed as the impact may affect the achievement of their objectives e.g. partners and key stakeholders.

11. Training and Awareness

This strategy and associated procedures will be disseminated throughout the ICBs regular communication channels and will be available on the intranet (Staff Hub) and public-facing website.

Training will be given to all new starters during corporate induction. This will include a briefing on the ICBs Risk Management Strategy and risk reporting processes.

Roles that manage risk e.g. inputting risks into the NHS C&M Risk Management System will also receive appropriate job-specification training.

Generic responsibilities in relation to the management of risks are included in individuals' job / role descriptions. Specific responsibilities in relation to managing risks will be outlined in job / role descriptions of relevant members of staff.

A corporate or directorate Governance Lead will attend committee or team meetings as required to discuss risk management and help develop awareness.

12. Dissemination and Implementation

This strategy & policy will be disseminated throughout NHS C&M via the regular communication channels and will be available on the intranet and website.

Generic responsibilities in relation to the management of risks are included in individuals' job / role descriptions. Specific responsibilities in relation to managing risks will be outlined in job / role descriptions of relevant members of staff; in addition to the responsibilities stated at section 4.

13. Equality and Diversity

This strategy and procedure should be read in conjunction with the ICB's Equality and Diversity Policy.

In applying this policy and procedure, the ICB will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups, in particular on the grounds of the following protected characteristics as outlined in the Equality Act (2010), in addition to offending background, trade union membership or any other personal characteristic.

The ICB values the diversity of its workforce and aims to ensure that all staff understand this commitment and adhere to the standards, and as such recognises that some

individuals with protected characteristics in NHS Cheshire and Merseyside may need additional support to understand and interpret this policy.

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Appendix 1 – Risk Appetite Statement

The Board has agreed to the following risk appetite statement, which will be reviewed and updated annually:

NHS Cheshire and Merseyside ICB has an overall **OPEN** appetite to risk. The Board recognises that successful delivery of its commissioning intentions, including neighbourhood health, prevention, service transformation and digital innovation requires informed and proportionate risk-taking**.**

The Board maintains a **CAUTIOUS** appetite in relation to patient safety, statutory compliance and stewardship of public resources.

The Board has an **OPEN** to **SEEK** appetite for innovation, transformation and new models of care where these support improved outcomes, reduced inequalities and long-term sustainability.

The Board will support well-managed risk-taking where this contributes to improved population health, financial sustainability and delivery of strategic objectives.

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Appendix 2 – Risk Scoring Matrix

Table 1A: Impact Score (I) Guidance

Impact Score	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Guidance	Negligible impact on objective/s Day to day operational challenges	Minor impact on objective/s. Temporary restriction to service delivery with limited impact on stakeholder confidence.	Moderate impact on objective/s. Short term failure to deliver key objectives with temporary adverse local publicity.	Major impact on objective/s. Medium term failure to deliver key objectives with ongoing adverse publicity or negative impact on stakeholder confidence.	Catastrophic impact on objective/s. Continued failure to deliver key objectives with long term adverse publicity or fundamental loss of stakeholder confidence.

Table 1B: Impact Score (I) Further Guidance broken by Risk Domain

The following domain-specific descriptors provide additional guidance to support consistent assessment of impact. They should be applied alongside the general impact score guidance in Table 1A and considered in the context of the objective affected by the risk. Where a risk spans more than one domain, the impact score should reflect the most significant credible consequence.

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Risk Domain	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Quality and Access: Risks that people do not receive safe, effective, high-quality and timely care due to failures in quality oversight, service access, capacity, performance or patient experience**.**	No, or very limited, impact on patient safety, clinical effectiveness, access or patient experience. Any issue is isolated and readily managed through routine/BAU processes	Minor or 'localised' impact on access, quality or experience, with limited disruption and no significant risk of harm.	Noticeable deterioration in quality, access or experience affecting a service, pathway or population group, requiring management action and oversight	Significant deterioration in quality, access or experience, with increased risk of avoidable harm, sustained service pressures or formal escalation through governance arrangements.	Severe or widespread failure in quality, safety, access or experience, with actual or likely serious harm, loss of confidence or need for system level intervention
Legal and Regulatory Compliance: Risks of non-compliance with legislation, statutory duties, regulatory requirements, or other mandatory obligations, resulting in enforcement action, legal challenge or loss of public confidence.	No breach, or minor technical non-compliance, with no material consequence and readily correctable through routine action/BAU.	Isolated or low-level non-compliance with limited impact, requiring local corrective action but unlikely to result in enforcement or formal challenge.	Confirmed non-compliance with statutory, regulatory or mandatory requirements, requiring formal action, reporting or external engagement.	Significant or repeated non-compliance, with risk of enforcement action, legal challenge, regulatory intervention or material loss of confidence and/or critical report.	Severe or systemic non-compliance resulting in, or likely to result in, prosecution, major regulatory action, critical findings or significant loss of public confidence and/or severely critical report.
Health Outcomes and Inequalities: Risks that the ICBs fail to improve population health outcomes or reduce health inequalities, including failure to target interventions effectively, address unwarranted variation, deliver prevention activity, or achieve improvements in health and wellbeing for the populations served**.**	No material impact on population health outcomes or inequalities; any effect is limited, short-term and easily addressed.	Minor impact on a small group or locality, with limited effect on access, outcomes or inequalities.	Measurable or noticeable impact on outcomes or inequalities for a defined population, pathway or locality, requiring targeted corrective action.	Significant impact on population outcomes or inequalities, with substantial variation in access, experience or outcomes and risk to delivery of strategic objectives.	Severe or widespread deterioration in outcomes or inequalities, with long-term consequences for population health, major inequity or substantial failure to deliver statutory ambitions.

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Risk Domain	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Workforce and Organisational Capability: Risks that the ICBs lack the workforce capacity, capability, leadership, culture or organisational resilience required to deliver its objectives and statutory responsibilities effectively.	Capability, leadership, culture or resilience; objectives remain deliverable through routine management.	Causing limited disruption to delivery, with manageable local action required.	Leadership, cultural or capability pressures affecting delivery of objectives, staff experience or organisational effectiveness.	Organisational capability failure, including loss of key capacity, leadership instability, poor culture or reduced resilience affecting delivery of statutory responsibilities.	Failure resulting in inability to deliver key functions, maintain safe operations or discharge statutory responsibilities effectively.
Financial Sustainability and Resource Allocation: Risks that the ICBs fail to achieve financial sustainability or maximise value from available resources, including ineffective resource allocation, poor productivity, inefficiencies, commissioning decisions or inability to meet financial duties.	No material financial impact, or negligible effect on resource use, productivity, value for money or financial duties. **Risk of loss negligible.**	Minor financial pressure, inefficiency or resource allocation issue, manageable within existing plans and controls. **Financial impact / loss of up to £1m**	Material financial pressure, inefficiency or sub optimal resource allocation affecting delivery of plans, productivity or value for money. **Financial impact / loss of up to £5m**	Significant financial risk affecting delivery of statutory duties, financial balance, investment decisions or ability to allocate resources effectively. **Financial impact / loss of up to £10m**	Severe financial failure or unsustainable resource position, with inability to meet financial duties, maintain services or support strategic objectives. **Financial impact / loss above £10m**
Partnerships and Social Value: Risks arising from ineffective leadership, collaboration or stakeholder engagement, leading to reduced system effectiveness, failure to deliver shared objectives, loss of confidence, reputational damage, or reduced social value.	No material impact on partnership relationships, stakeholder confidence, collaboration or social value.	Minor tensions or limited stakeholder concern, with negligible impact on delivery of shared objectives.	Deterioration in relationships, collaboration or stakeholder confidence affecting coordination, delivery or the ability to realise shared benefits.	Significant breakdown in partnership working, stakeholder engagement or collective leadership, with sustained impact on delivery, confidence or social value.	System-wide failure of collaboration or confidence, causing substantial loss of trust, inability to deliver shared objectives or major reputational damage.

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Risk Domain	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Planning and Transformation: Risks that the ICBs are unable to effectively plan, design and deliver services, programmes and transformation required to meet current and future population needs, including implementation of new care models, service redesign, strategic planning and major change initiatives.	No material disruption to planning, programme delivery, transformation or implementation of agreed change.	Minor delay, dependency issue or planning gap, with limited impact on delivery and manageable through routine programme controls.	Noticeable delay, slippage or delivery risk affecting a programme, service redesign or strategic planning objective, requiring formal corrective action.	Significant failure or sustained slippage in planning or transformation, affecting delivery of major change, strategic objectives or expected benefits.	Fundamental failure to plan, deliver or implement major transformation, resulting in long term inability to meet population needs, deliver strategic objectives or maintain system confidence.

The likelihood of the risk occurring must then be measured. Table 2 below should be used to assess the likelihood and obtain a likelihood score. When assessing the likelihood it is important to take into consideration the existing controls (i.e. mitigating factors that may prevent the risk occurring) already in place.

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Table 2 – Risk Likelihood Score Guidance

1	2	3	4	5
Rare The event could only occur in exceptional circumstances (<5%)	Unlikely The event could occur at some time (<25%)	Possible The event may well occur at some time (25%> -50%)	Likely The event will occur in most circumstances (50% > 75%)	Almost certain The event is almost certain to occur (>75%)

The impact and likelihood scores must then be multiplied and plotted on table 3 to establish the overall level of risk and necessary action.

LIKELIHOOD of risk being realised	**IMPACT (severity) of risk being realised**				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Almost Certain (5)	5	10	15	20	25

Low Risk	Moderate Risk	High Risk	Extreme Risk	Critical Risk

Risk Proximity

A further element to be considered in the risk assessment process is risk proximity. Risk proximity provides an estimate of the timescale as to when the risk is likely to materialise. It supports the ability to prioritise risks and informs the appropriate response in the monitoring of controls and development of actions.

The proximity scale used is below:

Proximity and timescale for dealing with the risk	**Within 3 months**	**Within 12 months**	**Beyond 12 months**
Rating	**A**	**B**	**C**
Likelihood, impact and proximity are dynamic elements and consequently all three must be reviewed and reassessed frequently in order to prioritise the response.			

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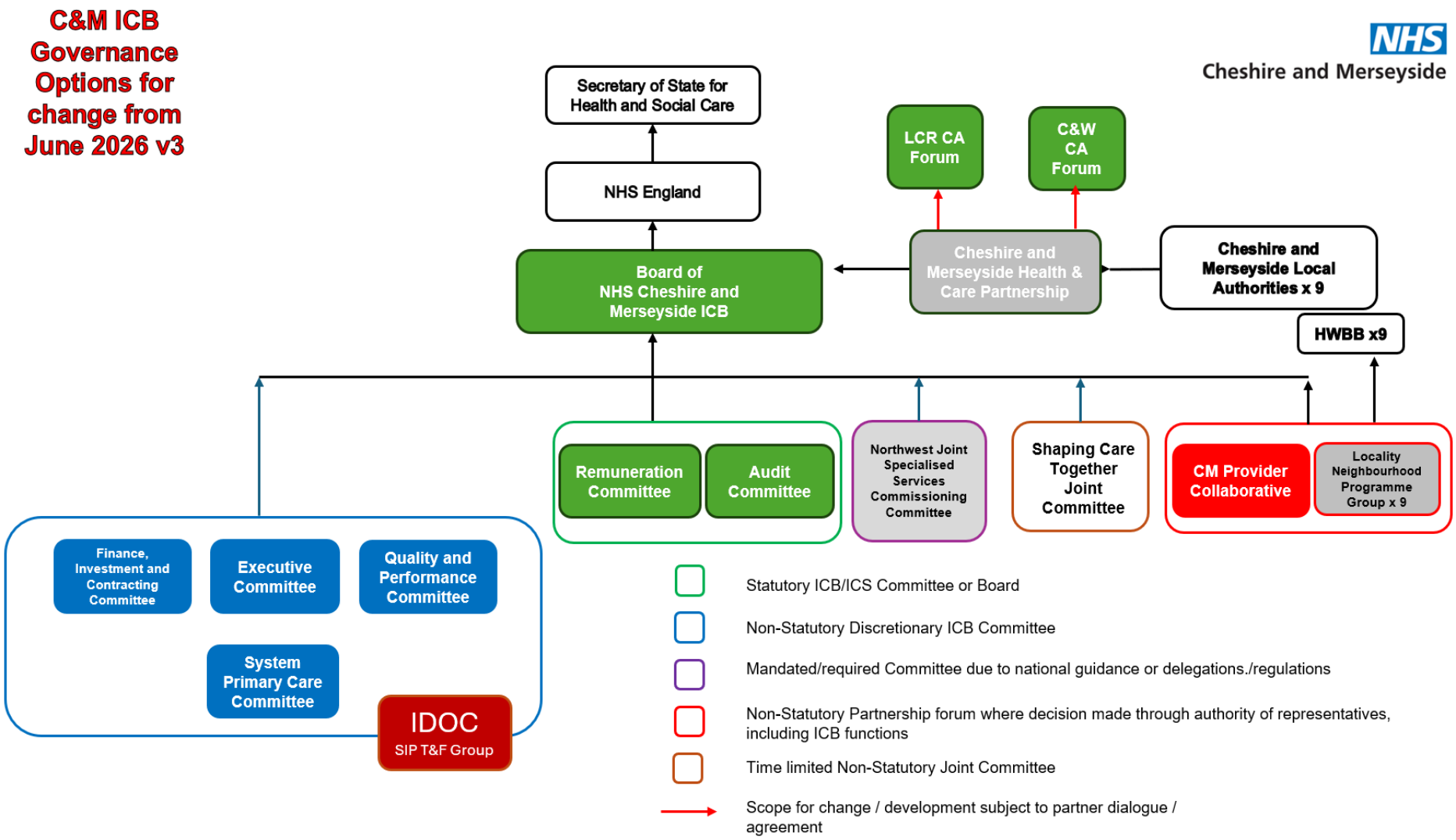
Appendix 3 – NHS Cheshire & Merseyside ICB Governance Schematic



Appendix 4 - Risk Escalation & De-escalation Thresholds

Risk escalation within NHS C&M supports the established leadership and reporting processes as described below. Risks will similarly be de-escalated where risk ratings reduce.

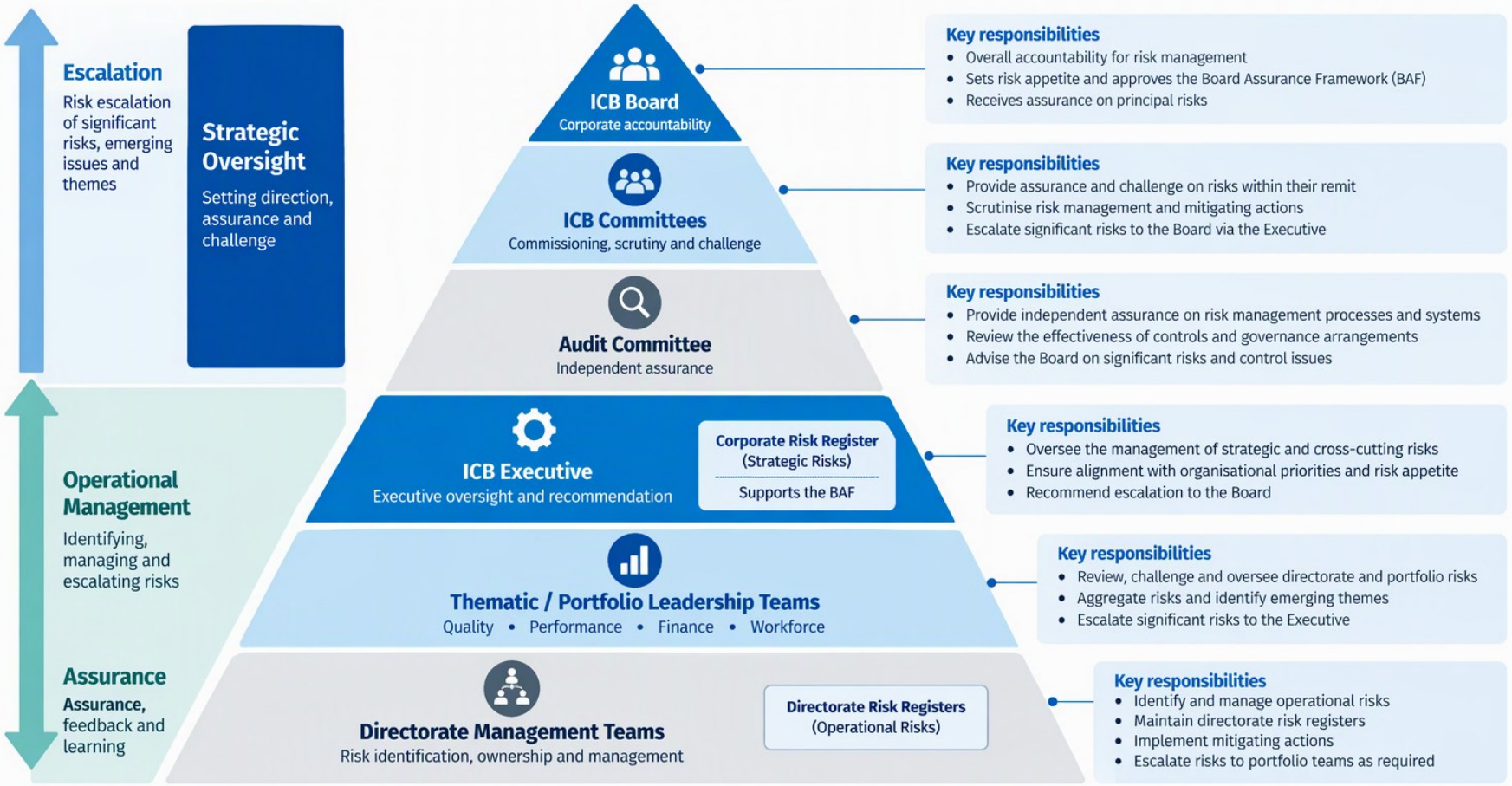
Risk Register	Inclusion / Escalation Criteria	De-escalation Criteria	Oversight By
Board Assurance Framework	• Principal risks to delivery of ICB strategic objectives • Identified by Board / recommended by Executive Committee • Approved for inclusion by the Board • Extreme / high inherent score • Reviewed annually	• Target score is met and aligned to risk appetite • Board is assured that controls are effective & approves de-escalation • **CLOSE** if current impact score reduces to less than 3 • **CLOSE** if objective is achieved / target score met / no longer required	ICB Board
Corporate Risk Register	• Corporate risks scoring 15+ • Major programme / project failure risk meeting criteria for 15+ • Reviewed by relevant ICB Committee and by Corporate Assurance Group	• Current risk score reduces below 15 • **CLOSE** if inherent impact score reduces to lower than 3 • **CLOSE** if objective is achieved / target score met / no longer required	ICB Board
Committee Risk Registers	• BAF risks assigned by the Board for assurance and oversight • Programme and directorate risks scored at 12+ • Major programme / project failure risk (scoring 12+)	• Current risk rating reduces to below 8 • **CLOSE** if current impact score reduces to 2 or below • **CLOSE** if objective is achieved / target score met / no longer required	ICB Committee
Directorate Risk Registers	• Risks scoring 8+ or where risk cannot be managed by originating team or programme • Existing controls are insufficient to reduce risk to an acceptable level • Risk has cross service, cross directorate or strategic implications	• Evidence /assurance that controls & mitigations are effectively managing risk • Current risk score has reduced to below 8 • Agreement risk owner and the relevant directorate governance forum that directorate-level oversight is no longer required •	Management Team

DRAFT

Risk Escalation and Assurance Framework

C&M ICB Risk Management – Roles and Responsibilities

NHS
Cheshire and Merseyside
Integrated Care Board



Effective risk management relies on clear ownership, timely escalation and robust assurance across all levels of the ICB.

Note: This diagram describes the ICB's risk escalation and assurance arrangements.
NHS partners may also need to escalate risks in accordance with their own risk management / assurance processes.

Better health
Brighter futures

Meeting of the Board of NHS Cheshire and Merseyside

26 November 2026

Integrated Research and Innovation System (IRIS): Research Performance, Board Assurance and Strategic Priorities

Agenda Item No: ICB/11/26/26/13

Responsible Director: Fiona Lemmens, Executive Clinical Director

REPORT SUMMARY SNAPSHOT

Required Information	Details				
Responsible Executive Director	Dr Fiona Lemmens				
Report approval	**By**	*Dr Fiona Lemmens (Clinical Executive Director)*			
	Date	*16/11/2026*			
Presented by	*Dr Fiona Lemmens (Executive Clinical Director)* *Professor Greg Irving (Clinical Lead for Research and Innovation)*				
Ask of the Board	**Approval**	✓	**Decision**		
	Endorsement	✓	**Ratification**		
	Receive assurance	✓	**Note**	✓	
Route to Board – where has this report been discussed	*CM ICB R&I System Oversight Group*				
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; P15: System fragmentation; P16: Neighbourhood/community care; P13: Financial sustainability/productivity (strategic alignment, not a change to risk scoring)*				
Financial Implications*	**Yes**		**No**	✓	
	If Yes:				
	Have the financial implications been reviewed by the Director of Finance	×			
	Has a budget been identified	×			
Legal Implications*	No new legal approval sought; research governance and information governance remain with responsible organisations				
Conflicts of Interest associated with this report	N/A				
Impact assessments undertaken*	**Equality**	×			
	Quality	×			
	Data	×			
	Sustainability	×			
Public or Clinical engagement undertaken	Informed by existing research and engagement programmes including Research Engagement Network; no separate consultation undertaken for this report.				

Integrated Research and Innovation System (IRIS): Research Performance, Board Assurance and Strategic Priorities

1. Executive Summary

1.1 This paper provides the Board with an update on research activity, performance and strategic priorities across Cheshire and Merseyside (C&M), using NHS England's *Framework for NHS Boards: Monitoring Research Activity* and its characteristics of high performing, research active organisations as the principal basis for assurance (see appendix 1).

1.2 IRIS provides a system-wide approach to research and innovation across Cheshire and Merseyside, supporting collaboration, evidence generation, research delivery and innovation adoption to improve population health, patient outcomes and economic growth. IRIS facilitates and convenes system-wide evidence, partnerships and collaboration, leveraging assets across Liverpool Health Partners, the NIHR infrastructure, universities, Health Innovation North West Coast, the NIHR North West Regional Research Delivery Network and other system partners, while provider delivery accountabilities remain local.

1.3 Primary care research performance remains strong. During 2025/26, the NIHR recorded 4,883 research activity records across 55 recruiting studies, including 267 commercial and 4,616 non-commercial activity records. Research-active GP practices collectively serve approximately 1.19 million patients (43% of the registered population). C&M ranked second among the ICBs included in the available national dashboard extract, although this has not been verified against the complete national dataset (see appendix 2).

1.4 Secondary care research has demonstrated substantial growth. NHS trust recruitment increased from 22,103 participants in 2024/25 to 38,958 in 2025/26, an increase of 76.3%. This represents the second-highest recruitment among the three North West ICB areas, behind Greater Manchester (45,166) and ahead of Lancashire and South Cumbria (14,899). A further 11,661 recruits were reported for 2026/27 at the August reporting point, although these figures remain provisional.

1.5 The research and innovation priorities endorsed by the Board in May 2025 focused on population health, neighbourhood health and reducing inequalities. These remain closely aligned with the Clinical and Strategic Commissioning Strategy, particularly its emphasis on prevention, digital transformation, integrated care and evidence-informed commissioning.

Research and innovation provide important opportunities to evaluate new models of care, improve outcomes and support productivity.

1.6 National policy further reinforces these priorities. The *Medium Term Planning Framework* strengthens expectations around clinical trial set-up, research income and six-monthly reporting to NHS provider boards. The *Model ICB Blueprint* emphasises strategic commissioning, population health intelligence, evaluation and effective partnerships. The Integrated Research and Innovation System (IRIS) provides an established mechanism for coordinating these activities across the system while recognising the operational responsibilities of individual providers.

1.7 Building on this strong performance, the next phase will focus on strengthening system-wide assurance and demonstrating the impact of research and innovation. A six-monthly IRIS performance dashboard is proposed, bringing together verified primary and secondary care activity, clinical trial delivery, commercial research income, workforce development and equitable participation. This will be complemented by evidence of research impact and clearly differentiated regional and national benchmarks, providing the Board with a consistent assessment of research performance and its contribution to the ICB's strategic objectives.

2. Ask of the Board and Recommendations

2.1 **The Board/ is asked to:**

- Note strong research performance across care settings, including 38,958 Cheshire and Merseyside NHS trust research recruits in 2025/26 (up 76.3% from 2024/25) and 4,883 recorded primary care research activity events across 55 studies.
- Recognise progress against the research and innovation priorities reported to the Board in May 2025.
- Endorse development of a six-monthly system research performance and assurance report aligned with the NHS England research monitoring framework, alongside a separate innovation metrics report developed with the Health Innovation Network to provide complementary oversight of innovation activity in Cheshire and Merseyside.
- Support the strategic contribution of IRIS to the Clinical and Strategic Commissioning Strategy and delivery arrangements, including neighbourhood health, prevention, inequalities and evidence-informed commissioning.

- Note that C&M NHS trust recruitment is now quantified, while trust-level study portfolios, trial set-up, commercial income, workforce and research impact require further consolidation.

3. Introduction / Background

3.1. This paper provides the Board with an update on research activity and performance across Cheshire and Merseyside. NHS England's Framework for NHS Boards: Monitoring Research Activity is the principal basis for assurance.

3.2 It builds on the IRIS research and innovation priorities presented to the Board in May 2025 and considers alignment with the Cheshire and Merseyside Clinical and Strategic Commissioning Strategy and delivery arrangements, the Medium Term Planning Framework 2026/27–2028/29 and the Model ICB Blueprint.

3.3 It describes performance in primary and secondary care, strategic enablers and a proportionate approach to future Board reporting on research delivery, inclusion, investment and impact.

4. Key areas of Note, Discussion and Assurance for the Board / Committee

4.1 Framework for NHS Boards: Monitoring Research Activity

The NHS England Framework for NHS Boards: Monitoring Research Activity provides the principal basis for Board assurance. It supports oversight of research activity, leadership, infrastructure, participation, delivery and impact. The proposed IRIS dashboard will combine national indicators, locally collected performance measures and qualitative evidence of research impact. This will provide a balanced assessment of research performance across primary, secondary and community care.

4.2 Medium Term Planning Framework 2026/27–2028/29

Section 2.8, Genomics, life sciences and research, reinforces the importance of clinical research, efficient study set-up and commercial research. It requires six-monthly reporting to NHS provider boards on research activity and income, including commercial income and reinvestment in research capacity. Provider responsibilities contributing to the national 150-day clinical trial set-up ambition should be considered separately from the NHS Oversight Framework's 90-day indicator.

4.3 Model ICB Blueprint

The Model ICB Blueprint emphasises strategic commissioning, population health intelligence, evaluation, outcomes and effective partnerships. It envisages research development and innovation functions moving towards regional arrangements while recognising the importance of continued ICB strategic partnerships. IRIS provides an established mechanism to support evidence-informed commissioning and system-wide research coordination, while operational delivery and organisational accountabilities remain with relevant providers and partners.

4.4 The refreshed 2026–2031 Clinical and Strategic Commissioning Plan and Population Health Improvement Plan provide the local strategic context for IRIS. The earlier Joint Forward Plan (JFP) Delivery Plan identified research and innovation as a priority programme, including development of a research and innovation strategy to maximise inward investment and research capacity.

IRIS contributes to the Clinical and Strategic Commissioning Strategy by embedding research and evaluation within neighbourhood health models, supporting prevention and long-term condition management through linked data and applied research, widening participation among underserved communities and informing service redesign, innovation adoption and productivity.

4.5 Research Performance Across Care Settings

4.5.1 Primary Care Research Performance, 2025/26

Cheshire and Merseyside continues to demonstrate strong primary care research performance. The NIHR Research Delivery Network 2025/26 dashboard reports:

Measure	C&M 2025/26
Primary care research activity	4,883
Recruiting studies	55
Commercial research activity	267
Non-commercial research activity	4,616
Registered primary care population	2,772,450
Population registered at research-active GP practices	1,193,177
Research-active practice population coverage	43.0%
Dashboard activity rate per 1,000 population	1.80

Research-active GP practices collectively serve approximately 1.19 million patients, representing 43% of the registered primary care population. This

measures population coverage through research-active practices rather than direct research participation.

Cheshire and Merseyside ranked second among the ICBs visible in the supplied NIHR dashboard extract, demonstrating the scale of its primary care research activity. This position has not been verified against the complete national dataset.

4.5.2 Secondary Care Research Performance

Secondary care research represents a substantial strength of Cheshire and Merseyside, supported by research-active acute, specialist, mental health and other NHS providers.

NHS England's North West Monthly Research Update (August 2026, page 13) reports 38,958 research participants recruited through Cheshire and Merseyside NHS trusts during 2025/26, compared with 22,103 in 2024/25. This represents an increase of 16,855 participants (76.3%), demonstrating substantial growth in reported research recruitment. Cheshire and Merseyside recorded the second-highest NHS trust recruitment among the three North West ICB areas.

North West ICB area	2024/25	2025/26	2026/27 YTD*
Cheshire and Merseyside	22,103	38,958	11,661
Greater Manchester	46,148	45,166	11,978
Lancashire and South Cumbria	13,709	14,899	4,706

*2026/27 figures represent partial-year recruitment at the August 2026 reporting point and remain subject to reporting updates.

These figures demonstrate the significant contribution of NHS trusts to research delivery across Cheshire and Merseyside. They encompass recruitment reported through the NIHR dataset and are not restricted to hospital-based interventional clinical trials.

Future assurance will build on this established recruitment baseline by incorporating provider-level recruiting studies, commercial and non-commercial research activity, clinical trial set-up, delivery to time and target, research income and patient benefit.

Secondary care assurance domain	Cheshire and Merseyside position

Research recruitment	38,958 NHS trust recruits in 2025/26, an increase of 76.3%
Recruiting studies	Provider-level data to be consolidated
Commercial and non-commercial research	Portfolio breakdown to be consolidated
Clinical trial set-up and delivery	C&M-specific performance data required
Commercial research income	Provider-level income and reinvestment data required
Research impact	Provider case studies and evidence of patient benefit to be collated

4.5.3 Research in Community and Residential Care Settings

Research delivery across community services, care homes and other residential settings is an important opportunity to extend participation beyond general practice and hospitals. These settings serve people with frailty, multiple long-term conditions, disabilities and complex health and social care needs who may otherwise have limited access to research. The next phase of IRIS will support closer collaboration between NHS community providers, primary care, local authorities, social care organisations and NIHR delivery partners to identify feasible studies and develop proportionate research delivery arrangements.

The North West Coast Applied Research Collaboration (ARC) Research, Engagement Network (REN) and VCFSE North West partners provide essential routes for involving residents and communities in setting priorities, shaping study design and improving awareness, trust and access. Place-based engagement, accessible information and trusted community organisations can help address barriers to participation, particularly in underserved and deprived populations. Engagement should include residents, families, carers and care staff where appropriate, with attention to consent, capacity, safeguarding and the practical demands of research in residential settings.

Future assurance will seek to capture community and residential-setting research activity, involvement of VCFSE partners, reach into underserved groups and examples of research informing care delivery. Comparable baseline activity figures are not yet available in the supplied datasets, so no recruitment totals are attributed to these settings. This work supports the May 2025 IRIS priorities for neighbourhood health, inclusion and research closer to home.

4.5.4 Benchmarking and Inclusive Research

Cheshire and Merseyside's performance compares favourably with other major research-active systems. Primary care activity exceeded that reported for Greater Manchester, Hampshire and Isle of Wight, and Bristol, North Somerset and South Gloucestershire within the available dashboard extract. The May 2025 Board paper also highlighted Cheshire and Merseyside's strengths in widening research participation, particularly among people living in deprived communities.

Future reporting will strengthen the assessment of research inclusion through measures of participation by geography, deprivation and population group, wherever reliable data are available. This will support the ICB's commitment to reducing inequalities and improving equitable access to research.

4.5.5 Clinical Trial Set-Up and Research Income

Efficient clinical trial delivery and commercial research investment are important components of a high-performing research-active system. The NHS England North West September 2026 research update includes regional and England-wide performance information for the 90-day clinical trial set-up indicator. These figures should not be interpreted as Cheshire and Merseyside-specific performance.

Future IRIS reporting will seek verified local information on clinical trial set-up, recruitment to time and target, commercial research income and reinvestment in research capacity. The 90-day NHS Oversight Framework indicator and the national 150-day trial set-up ambition will be reported separately.

4.6 Progress Against May 2025 IRIS Priorities

The May 2025 Board paper established population health, neighbourhood health and reducing inequalities as central research and innovation priorities. These remain closely aligned with the Clinical and Strategic Commissioning Strategy and the national direction of NHS reform.

Established priority	Contribution and next phase
Population health	Linked data, applied research and evaluation to inform prevention and long-term condition management

Neighbourhood health	Embedding research and evaluation within community and integrated neighbourhood services
Reducing inequalities	Widening participation through community engagement and inclusive research delivery
External investment	Coordinating NIHR, academic, industry and commercial research opportunities
Evidence into practice	Connecting applied research with commissioning, service improvement and innovation adoption
Research workforce	Supporting research delivery capacity and clinical academic development

IRIS is progressing from establishing a coordinated partnership towards demonstrating the collective performance, reach and impact of the research and innovation ecosystem. This builds on the May 2025 priorities and the system's I.M.P.R.O.V.E. framework.

4.7 Strategic Enablers

Cheshire and Merseyside benefits from an extensive research and innovation ecosystem, bringing together NHS organisations, universities, NIHR infrastructure, industry partners, local authorities and community organisations.

The May 2025 Board paper identified several strategic enablers that collectively provide the infrastructure, expertise and partnerships necessary to support a high-performing research-active system.

Strategic enabler	Contribution
Research Engagement Network	Community engagement and inclusive research participation
Civic Health Innovation Labs and Secure Data Environment	Linked data, population health intelligence, analytics and evaluation
NIHR North West Coast Applied Research Collaboration	Applied research, implementation and research capacity
Universities and higher education institutions	Academic expertise, external funding and clinical academic workforce development
NIHR Research Delivery Network	Study delivery, research hubs and research capacity across care settings
Commercial Research Delivery Centre (CRDC) & PC-CRDC	Industry partnerships, commercial research capacity and access to innovative treatments
Health Innovation North West Coast	Evaluation, adoption and spread of innovations

Liverpool Health Partners	Strategic academic and NHS research collaboration
Place-based research collaborations	Locally responsive research and neighbourhood health evaluation
Hartree Centre, Life Sciences Investment Zone and Champs Public Health Collaborative	Advanced computing, commercial innovation, population health and prevention

The May 2025 Board paper reported £5.7 million investment in the Commercial Research Delivery Centre, a £14.6 million NIHR Applied Research Collaboration programme award and historical cumulative ARC external funding of just under £48.8 million. These figures demonstrate the scale of established research investment and should not be interpreted as current-year income.

The next phase of IRIS will focus on maximising the collective contribution of these strategic enablers, strengthening coordination, attracting investment and ensuring research and innovation are aligned with the ICB's strategic priorities.

4.8 Research Impact and Evidence-Informed Commissioning

The next phase of IRIS will place greater emphasis on demonstrating how research and innovation contribute to improved patient outcomes, equitable access to innovative treatments, prevention, service redesign, workforce development, productivity and economic growth.

Impact reporting will draw on NHS provider and academic case studies, evaluation evidence and examples of research findings informing clinical practice or commissioning decisions. This will strengthen the connection between the May 2025 I.M.P.R.O.V.E. ambition, the Clinical and Strategic Commissioning Strategy and the strategic commissioning functions described in the Model ICB Blueprint.

4.9 Innovation Performance, Adoption and Spread

Innovation is a core component of the Integrated Research and Innovation System (IRIS), supporting the translation of research evidence into improvements in patient outcomes, service delivery and productivity. NHS England's *Innovation Ecosystem Programme* emphasises the importance of monitoring the adoption, spread and impact of evidence-based innovations. The NHS Innovation Scorecard also provides nationally published information on the uptake of selected NICE-approved treatments, enabling comparison between

NHS organisations and identification of variation in adoption.
Working with Health Innovation North West Coast, NHS providers and academic partners, IRIS will develop a proportionate set of innovation performance indicators. These will include the number of innovations adopted into routine care, spread across providers and neighbourhoods, patients benefiting, measurable improvements in outcomes and inequalities, and validated productivity and financial benefits.

These measures will complement existing research activity indicators, enabling the Board to assess not only the scale of research undertaken across Cheshire and Merseyside but also the extent to which research and innovation are translated into improvements in health and care.

4.10 Risks and Mitigations

The principal risks relate to fragmented research coordination, unequal access to research opportunities, insufficient evidence to inform commissioning decisions and missed opportunities to attract commercial research investment.

These risks are mitigated through established IRIS partnerships, NIHR research delivery infrastructure, community engagement, place-based collaborations and the proposed six-monthly research performance dashboard.

P12: Failure to reduce health inequalities and improve population health.
P15: System fragmentation and provider sustainability.
P16: Failure to deliver the shift to neighbourhood and community-based care.
P13: Inability to achieve financial sustainability and productivity.
Formal alignment with these risks should be confirmed with the relevant risk owners.

4.11 Finance

No additional ICB funding is requested through this paper. Research income and external investment remain the responsibility of the relevant recipient organisations. IRIS will continue to support opportunities to attract external funding and maximise the value of existing research infrastructure.

Future assurance reporting will improve visibility of commercial research income, external investment and reinvestment in research delivery capacity, subject to validation with NHS providers and research partners.

4.12 Communication and Engagement.

IRIS operates through established partnerships involving NHS organisations, universities, NIHR infrastructure, local authorities, industry and voluntary and community sector organisations.

The Research Engagement Network and place-based research collaborations support engagement with underserved populations and help ensure that research priorities reflect local needs.

Further engagement with NHS providers, research delivery partners and academic organisations will inform the development of the proposed performance dashboard, the identification of research impact case studies and the alignment of research priorities with the Clinical and Strategic Commissioning Strategy.

5. Next Steps and Responsible Person to take forward

5.1 Dr Fiona Lemmens (C&M Executive Clinical Director), supported by the IRIS partnership and relevant NIHR and NHS provider leads, will oversee development of a six-monthly system assurance report. This will reconcile NHS trust recruitment by provider, strengthen clinical trial set-up and commercial income reporting, and identify evidence of patient and population impact.

5.2 The proposed approach will be communicated to relevant ICB, provider, NIHR and academic partners. The first consolidated return will be brought back through the agreed governance route, with a six-monthly Board reporting cycle proposed.

6. Appendices

Appendix One: Evidence and Reference Documents
Appendix Two: Research Performance Dashboard
Appendix Three: Supplementary Information - CM R&I System Oversight Group (SOG) Terms of Reference
Appendix Four: Supplementary information - Slide Deck – Research Performance, Board Assurance and Strategic Priorities

Appendix One: Evidence and Reference Documents

• NHS England, Framework for NHS Boards: Monitoring Research Activity.
• NHS England, Medium Term Planning Framework: Delivering Change Together 2026/27–2028/29 (October 2025).
• NHS England, Model Integrated Care Board Blueprint v1.0 (May 2025).
• NHS Cheshire and Merseyside, Joint Forward Plan and Delivery Plans.
• NHS Cheshire and Merseyside, IRIS Research and Innovation Priorities, Board paper 29 May 2025.
• NIHR Research Delivery Network, ICB Primary Care Delivery dashboard 2025/26.
• NHS England, North West Monthly Research Update (August 2026), page 13 (NHS trust recruitment).

Appendix Two: Research Performance Dashboard

Measure	**C&M 2025/26**
Primary care activity (NIHR dashboard)	4,883
Recruiting studies	55
Commercial primary care activity	267
Non-commercial primary care activity	4,616
Registered practice population	2,772,450
Registered at research-active practices	1,193,177
Research-active practice population coverage	43.0%
Activity per 1,000 population (dashboard displayed)	1.80

Secondary care assurance domain	**C&M position**
Recruitment and active studies	38,958 NHS trust recruits in 2025/26 (22,103 in 2024/25); provider-level studies to follow
Commercial and non-commercial portfolio	Recruitment total available; commercial/non-commercial split to be consolidated
Clinical trial set-up / delivery to target	C&M-specific data required
Commercial research income and reinvestment	Provider-level figures required
Research impact and patient access	Trust examples and case studies to be collated

North West ICB area	**2024/25**	**2025/26**	**2026/27 YTD***
Cheshire and Merseyside	22,103	38,958	11,661
Greater Manchester	46,148	45,166	11,978
Lancashire and South Cumbria	13,709	14,899	4,706

Appendix Three: **CM R&I System Oversight Group (SOG) Terms of Reference**



Appendix 3 ToR Draft final 1.2.docx

Appendix Four: **Slide Deck – Research Performance, Board Assurance and Strategic Priorities**



Appendix 4 R&I SLIDE SET (1).pptx

Cheshire and Merseyside

NHS Cheshire & Merseyside ICB

C&M Research and Innovation System Oversight Group (SOG)

Terms of Reference

Refreshed Version - GM 18/11/26

1. Introduction and Purpose

The Research & Innovation System Oversight Group (the group) is established by NHS Cheshire & Merseyside Integrated Care Board as a group of the Executive Committee. The group provides strategic assurance, scrutiny and oversight of research and innovation activity across Cheshire & Merseyside and enables the Board via the Executive Committee to receive assurance regarding system research and innovation activity.

These terms of reference, which must be published on the NHS Cheshire and Merseyside website, set out the membership, the remit, responsibilities, and reporting arrangements of the group and may only be changed with the approval of the Executive Committee of NHS Cheshire and Merseyside.

The group members, including those who are not members of the Board, are bound by the Standing Orders and other policies of NHS Cheshire and Merseyside.

The group's main purpose is to exercise the functions of the ICB relating to the legal duties on ICBs, as outlined within the Health and Care Act 2022 (the 2022 Act), regarding the facilitation and promotion of research relevant to health service and the use in the health service of evidence obtained from research.

These duties have been emphasised in NHS England's subsequent guidance to ICBs on Maximising the Benefits of Research[1] which makes a number of recommendations on how best to embed a culture of research and innovation within an Integrated Care System (ICS). In addition, the NHS England *Framework for NHS Boards: Monitoring Research Activity* sets out expectations for Board oversight and assurance of research activity across NHS organisations, and informs the group's approach to monitoring, assurance and reporting.

2. Role and Responsibilities

The Research & Innovation System Oversight Group is established to provide strategic oversight, scrutiny and assurance in relation to research and innovation activity across Cheshire & Merseyside. The group is primarily an assurance and reporting committee and does not have an operational delivery function.

Through delegated authority from the ICB Board through the Executive Committee, the group will:

- provide strategic assurance on research and innovation activity across the system;
- consider key risks, opportunities and areas requiring escalation;
- act as a route of escalation to support the unblocking of issues related to research and innovation.
- promote collaboration and shared learning across partner organisations;
- receive and review standardised updates from member organisations;
- provide assurance, reports and recommendations to the ICB Board via the Executive Committee, including a summarised system-wide report on research and innovation activity.

Representatives of member organisations will:

- attend and actively participate in group meetings;
- represent the views and activities of their organisation/infrastructure;
- submit agreed updates and information to support the group's assurance function;
- support collaborative working across the system;
- declare and manage any conflicts of interest in accordance with ICB policies.

3. Authority

The Research and Innovation System Oversight Group is authorised by the ICB Board through the Executive Committee to:

- authorise requested information within its remit, receive reports from partner organisations, establish task and finish groups where appropriate and escalate matters to the ICB Board.
- investigate and approve any activity as outlined within its terms of reference.
- obtain 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 group must follow any procedures put in place by the ICB for obtaining legal or professional advice
- the group shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the constitution of the ICB, standing orders and SoRD but may /not delegate any decisions to such groups without the approval of the ICB Board via the Executive Group.
- commission, review and authorise policies where they are explicitly related to areas within the remit of the group as outlined within the TOR, or where specifically delegated to the group by the ICB Board via the Executive Committee.

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

4. Membership & Attendance

4.1 Membership

Membership will reflect the breadth of research and innovation activity across Cheshire & Merseyside.

The group's membership shall be confirmed by the ICB Executive Committee of NHS Cheshire and Merseyside via approval of the groups Terms of Reference and in accordance with the NHS Cheshire and Merseyside Constitution.

Membership of the group may be drawn from individuals employed by or appointed by NHS Cheshire and Merseyside, individuals drawn from partners within the wider health and social care system and other individuals / representatives as deemed appropriate for the delivery of the Committees/Groups remit.

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

The group membership will be composed of:

- Chair (Professor Paul Kingston)
- ICB Executive Clinical Director
- X2 ICB Directors of Research, Cheshire and Merseyside Integrated Care System
- Additional ICB Executive Director
- Liverpool Health Partners (LHP)
- Health Innovation Northwest Coast (HIN)
- Liverpool Adult Hospital Research and Innovation Co-operative (LAHRIC)
- Cheshire and Merseyside Commercial Research Delivery Centre (CRDC)
- Cheshire and Merseyside Primary Care - Commercial Research Delivery Centre (PC-CRDC)
- Civic Health Innovation Labs (CHIL)
- X4 One National Institute of Health Research (ONE NIHR):
    - Applied Research Collaboration Northwest Coast (ARC NWC)

    - NIHR Alder Hey Clinical Research Facility (CRF)
    - NIHR Health Protection Research Unit in Emerging and Zoonotic Infections (HPRU)
    - NIHR Liverpool Clinical Research Facility (CRF)
- C&M Local Authority Representative

4.2 Attendees

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

Meetings of the group may also be regularly attended by the following individuals who are not members of the group. Such attendees will not be eligible to vote.

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 matters.

5. Meetings

5.1 Leadership

The Chair and Deputy Chair shall be appointed by the ICB and will ensure meetings are conducted effectively and appropriate reports are submitted to Board via the ICB Executive Committee.

If the Chair, or Deputy Chair, is unable to attend a meeting, they may designate an alternative member of the group to act as Chair.

If the Chair is unable to chair an item of business due to a conflict of interest, the Deputy Chair will be asked to Chair the meeting. On the occasion where both the Chair and Deputy Chair are unable to Chair an item due to a conflict of interest, then another member of the group, without any conflicts, will be asked to chair the Meeting for that item. Where these requirements are unable to be met the meeting item will need to be deferred.

The Chair and ICB Executive Clinical Lead will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

5.2 Quorum

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

- at least 8 Committee members in total, of which this must consist of:
    - the Chair or Deputy Chair
    - at least one ICB Associate Director of Research and Innovation.
    - The ICB Executive Clinical Director

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

5.3 Decision-making and voting

Decisions will be taken in accordance with the Standing Orders and Operational Standing Orders of NHS Cheshire and Merseyside and within the authority as delegated to the group and its members. The group will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the group 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 group 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 meeting of the group.

5.4 Frequency and meeting arrangements

The group will meet in private.

The group will meet twice a year.

Additional meetings may take place as required.

At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the group shall prepare a schedule of meetings for the forthcoming year ("the Schedule").

Members may call for a special meeting of the group outside of the Schedule as they see fit, by giving notice of their request to the Chair. The Chair may, following consultation with the group members,

confirm the date on which the special meeting is to be held and then issue a notice giving not less than one week's notice of the special meeting.

The group may meet virtually and members attending using electronic means will be counted towards the quorum.

6. Administrative Support

Secretariat support will be provided by the ICB Research & Innovation Team. Which will include ensuring that:

- the agenda and papers are prepared and distributed having been agreed by the Chair with the support of the Executive Lead
- good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- the Executive Clinical Director is supported to prepare and deliver reports to the Board
- the group is updated on pertinent issues / areas of interest / policy developments; and
- action points are taken forward between meetings.

7. Accountability and Reporting

The group is accountable to the Executive Committee of NHS Cheshire and Merseyside and shall report to the Executive Committee on how it discharges its responsibilities.

The Executive Clinical Director will provide an annual assurance report to the Executive Committee and shall draw to the attention of the Executive Committee any issues that require disclosure to the Executive Committee or require action.

The group will also submit copies of its confirmed minutes to the Executive Committee of NHS Cheshire and Merseyside following each of its meetings.

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

8. Behaviours and Conduct

Members will be expected to conduct business in line with the NHS Cheshire and Merseyside values and objectives and principles.

Members of, and those attending, the group meeting shall behave in accordance with NHS Cheshire and Merseyside constitution, Standing Orders, and Standards of Business Conduct Policy.

All members shall comply with the NHS Cheshire and Merseyside Managing Conflicts of Interest Policy at all times. In accordance with the NHS Cheshire and Merseyside policy on managing conflicts of interest, the group members should: In accordance with the NHS Cheshire and Merseyside policy on managing conflicts of interest, group members should:

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

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

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

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

9. Review

The group will review its effectiveness at least annually

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

NHS
Cheshire and Merseyside

Cheshire and Merseyside Integrated Research and Innovation System (IRIS):

Research Performance, Board Assurance and Strategic Priorities



GLOSSARY

Acronym	Meaning
ARC	Applied Research Collaboration NorthWest Coast
CHIL	Civic Health Innovation Labs
CRDC	Commercial Research Delivery Centre
CRF	Clinical Research Facility
ECMC	Experimental Cancer Medicine Centre
EHU	Edge Hill University
HEI	Higher Education Institution
HIN	Health Innovation NorthWest Coast
HPRU	Health Protection Research Unit
IRIS	Integrated Research and Innovation System
LJMU	Liverpool John Moores University
LHP	Liverpool Health Partners
LSTM	Liverpool School of Tropical Medicine
NIHR	National Institute for Health and Care Research
PC-CRDC	Primary Care Commercial Research Delivery Centre
RDN	Research Delivery Network
REN	Research Engagement Network
UoL	University of Liverpool
VCFSE	Voluntary, Community, Faith and Social Enterprise Sector

1. Introduction and policy context

Cheshire and Merseyside

- May 2025 C&M Strategic Priorities paper
- NHS England Framework for NHS Boards: Monitoring Research Activity is the principle assurance basis NHS England » Framework for NHS boards: monitoring research activity
- Medium Term Planning Framework 2026/27–2028/29: clinical trials, commercial income and provider reporting
- Model ICB Blueprint: strategic commissioning, evaluation, population health intelligence and partnerships
- C&M Clinical and Strategic Commissioning Strategy

2. Ask of the Board / recommendations

NHS
Cheshire and Merseyside

- NOTE strong research performance across care settings
- RECOGNISE progress against priorities endorsed in May 2025
- SUPPORT IRIS contribution to the Clinical and Strategic Commissioning Strategy
- ENDORSE six-monthly system research performance and assurance reporting

Priorities, enablers and impact

NHS
Cheshire and Merseyside

- Priorities: population health, neighbourhood health, inequalities, investment, evidence into practice and workforce

- Enablers: **Liverpool Health Partners**, which includes:
  - LHP-One NHS a Research & Innovation co-operative across Liverpool's seven NHS Trusts
  - LHP-One NIHR, including:
    - Applied Research Collaboration North West Coast
    - Adult and Paediatric Clinical Research Facilities
    - Commercial Research Delivery Centres
    - Experimental Cancer Medicine Centre
    - Health Protection Research Unit in Emerging and Zoonotic Infections
  - University of Liverpool
  - Liverpool School of Tropical Medicine
  - Liverpool John Moores University
  - Health Innovation Northwest Coast
  - Northwest Regional Research Delivery Network
  - Edge Hill University

- Demonstrate impact on outcomes, equity, service redesign, productivity and commissioning

- Track innovations adopted, spread across providers, patients benefiting and validated value

Assurance framework and policy alignment

NHS
Cheshire and Merseyside

- IRIS facilitates/convenes system-wide evidence and partnerships; provider delivery accountabilities remain local
- Dashboard combines national measures, locally validated data and qualitative impact evidence
- Provider boards expected to report research activity and income every six months
- 90-day Clinical Trial NHSE oversight framework indicator
- National 150-day trial set-up ambition - Life Science Sector Plan

Performance against IRIS strategic priorities

Population health	Linked data and applied research underpin prevention, LTC management and population health intelligence. (ARC, LHP, CHIL)
Neighbourhood health	Research and evaluation being embedded in integrated, community and neighbourhood care. (ARC, HIN, LHPM RDN)
Reducing inequalities	Strong reach into underserved communities; future reporting will quantify participation by deprivation. (ARC, REN, HIN)
External investment	Established NIHR, academic and industry partnerships; coordinated investment opportunities. (ARC, CRDC, PC-CRDC, HIN)
Evidence into practice	Greater focus on evaluation, innovation adoption and evidence-informed commissioning. (ARC, LHP, HIN)
Research workforce	Research delivery infrastructure and clinical academic development supported across the system. (RDN, ARC, HEI, LHP)

Primary care | Strong reach and research activity

2025/26 NIHR dashboard • Second among ICBs in the available extract*

4,883

Research activity records

55

Studies recruiting

43.0%

Population covered by research-active practices *excluding PIC activity

- 1.19 million patients registered at research-active practices (3rd largest nationally)
- National leader in research recruitment from deprived communities
- 117 research active practices (35% v 29% nationally)
- 4,616 non-commercial | 267 commercial activity

https://public-odp.nihr.ac.uk/

NHS trusts

38,958 participants recruited in 2025/26 • +16,855 on previous year

CHESHIRE & MERSEYSIDE NHS TRUST RECRUITMENT

38,958 participants recruited in 2025/26

+76.3% year-on-year growth

+16,855 additional recruits

RECRUITMENT GROWTH



Community, residential care and inclusion

NHS
Cheshire and Merseyside

- Continue to extend research into community services, care homes and residential settings
- REN, ARC North West Coast and VCFSE and other partners support trusted engagement and co- design
- Measure research participation across Cheshire and Merseyside by protected characteristics, socioeconomic deprivation and geography to assess representativeness, identify inequalities and promote equitable access to research and innovation
- Monitor and promote Be Part of Research activity
- Validate local clinical trial set-up, commercial income and reinvestment data

Risks, finance

NHS
Cheshire and Merseyside

- Risks: fragmentation, unequal research access, insufficient commissioning evidence and missed investment
- Mitigation: IRIS coordination, NIHR infrastructure, community engagement and six-monthly dashboard
- No additional ICB funding requested; research income remains with recipient organizations'

Next steps

NHS
Cheshire and Merseyside

- Dr Fiona Lemmens (Executive Clinical Director) and IRIS partners to consolidate provider data, trial delivery income and patient impact

- Return first consolidated report through agreed governance, then six-monthly Board cycle

Meeting of the Board of NHS Cheshire and Merseyside

24 November 2026

Liverpool City Region (LCR) Health and Wellbeing Partnership Board – Brief and Terms of Reference

Agenda Item No: ICB/11/26/26/14

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

REPORT SUMMARY SNAPSHOT

Required Information	Details			
Responsible Executive Director	**Ben Vinter** *Executive Director of Corporate Services and Governance*			
Report approval	**By**	**Ben Vinter** *Executive Director of Corporate Services and Governance*		
	Date	19 November 2026		
Presented by	**Ian Ashworth.** *Director of Population Health*			
Ask of the Board	**Approval**		**Decision**	
	Endorsement	✓	**Ratification**	
	Receive assurance		**Note**	
Route to Board – where has this report been discussed	Developed jointly with Liverpool City Region Combined Authority and system partners; presented to Board for endorsement of the proposed partnership arrangements.			
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; P16 Failure to deliver the shift to neighbourhood and community-based care; P11 Digital and Cyber Resilience Gaps (data sharing ambitions)			
Financial Implications*	**Yes**		**No**	✓
	Ongoing support expected within existing resources			
	Have the financial implications been reviewed by the Director of Finance			✓
	Has a budget been identified			N/A
Legal Implications*	Supports partnership working with evolving Mayoral Strategic Authority health duties and wider system integration arrangements.			
Conflicts of Interest associated with this report	None identified.			
Impact assessments undertaken*	**Equality**			×
	Quality			×
	Data			×
	Sustainability			×
Public or Clinical engagement undertaken	Development undertaken in collaboration with local authorities, NHS organisations and wider partners.			

Liverpool City Region (LCR) Health and Wellbeing Partnership Board – Brief and Terms of Reference

1. Executive Summary

1.1. The Liverpool City Region Combined Authority (LCRCA), the six Liverpool City Region local authorities and Cheshire and Merseyside ICB have collaboratively developed proposals to establish a Liverpool City Region Health and Wellbeing Partnership Board. The proposed Board would operate as an informal joint committee to support collective leadership, joint working and shared decision-making aimed at improving population health and reducing health inequalities across the Liverpool City Region footprint.

1.2. The Partnership Board has been designed to support delivery of the Mayor's Health, Wellbeing and Public Service Reform competency, the Combined Authority's statutory health improvement and health inequalities responsibilities, and the shared ambitions of the Marmot City Region and All Together Fairer programmes. The Board's focus will be on prevention, early intervention, neighbourhood working and greater alignment between local government and NHS commissioning approaches.

1.3. The proposed arrangements will complement, rather than replace or duplicate, existing statutory health governance arrangements, including the six local Health and Wellbeing Boards, the CHAMPS Public Health Collaborative and NHS accountability arrangements.

1.4. The establishment of the Partnership Board aligns with NHS Cheshire and Merseyside's strategic objectives relating to improving population health, tackling health inequalities and supporting broader social and economic development through strengthened partnership working across the determinants of health.

2. Ask of the Board and Recommendations

2.1. The Board is asked to:

- **Endorse** NHS Cheshire and Merseyside's participation in the Liverpool City Region Health and Wellbeing Partnership Board.
- **Endorse** the proposed Terms of Reference for the Partnership Board as set out in Appendix 1.

- **Support** the continued development of collaborative arrangements with the Liverpool City Region Combined Authority and local authority partners to improve population health and reduce health inequalities across the Liverpool City Region.
- **Note** that any future recommendations requiring formal approval by the ICB will be brought through the appropriate governance route.

3. Introduction / Background

3.1. Recent national policy developments have increased expectations around collaboration between Mayoral Strategic Authorities, local government and NHS organisations in improving population health and reducing health inequalities. These developments support greater alignment across public sector organisations in addressing the wider determinants of health and delivering preventative approaches.

3.2. The Liverpool City Region Combined Authority has proposed establishing a Health and Wellbeing Partnership Board to provide a strategic forum for collaboration across local government, NHS and voluntary sector partners. The Board would focus on shared priorities relating to population health, prevention, reducing inequalities and neighbourhood health approaches.

3.3. The proposal aligns closely with NHS Cheshire and Merseyside's strategic priorities, particularly through supporting partnership arrangements that address health inequalities and improve outcomes across local communities.

4. Key areas of Note, Discussion and Assurance for the Board

4.1 Strategic Alignment

4.1.1. The proposed Partnership Board supports delivery of the ICB's prevention, population health management and health inequalities agenda through a formal partnership mechanism bringing together the Liverpool City Region Combined Authority, local government, NHS and wider system partners.

4.1.2. The Partnership Board will enable joint working and collaborative decision-making to improve population health and reduce health inequalities across the Liverpool City Region. Its role will be to drive prevention and early intervention, support the integration of health and wider public services at neighbourhood level, strengthen alignment between local government and NHS commissioning and investment decisions, agree shared priorities and an aligned work programme, and provide a forum for considering the implications of future policy and legislative developments.

4.1.3. The Board would complement existing health governance arrangements by explicitly connecting improvement in health outcomes to Combined Authority and partner levers that shape the conditions into which people are born, grow, live,

work and age, including transport and local infrastructure; skills and employment support; housing and strategic planning; inclusive economic development and regeneration; the environment and climate change; public safety; and culture.

4.1.4. The Board will support a whole-system approach to addressing these wider determinants of health, whilst promoting opportunities for shared intelligence, population health management and evidence-based approaches to prevention. The proposed arrangements also support delivery of the Liverpool City Region's Marmot City Region and All Together Fairer ambitions through strengthened partnership working focused on health equity and reducing inequalities.

4.2 Governance

4.2.1. The Partnership Board will operate as an advisory and collaborative forum rather than a statutory decision-making body. Recommendations will be made to partner organisations, including the ICB, for formal consideration through existing governance arrangements where required.

4.2.2. The Partnership Board will be chaired by the Cabinet Member for Public Service Innovation at the Liverpool City Region Combined Authority, with the Chair of Cheshire and Merseyside ICB serving as Vice Chair.

4.3 Risks

4.3.1. The principal risk of not participating is the potential loss of strategic influence in shaping Liverpool City Region-wide approaches to prevention, health improvement and reducing inequalities.

4.3.2. There is a risk of duplication with existing partnership arrangements; however, the Terms of Reference explicitly state that the Board is intended to complement and augment the work of the Health and Wellbeing Boards, the CHAMPS Public Health Collaborative and existing NHS accountability arrangements.

4.4 Financial Implications

4.4.1. No direct financial implications arise from endorsement of the Terms of Reference. Participation and administrative support are expected to be managed within existing organisational resources.

5. Next Steps and Responsible Person to take forward

5.1. Subject to Board endorsement:

- NHS Cheshire and Merseyside will continue to work with Liverpool City Region Combined Authority and partners to finalise governance arrangements.

- The Partnership Board will be established and commence development of a shared work programme focused on population health and health inequalities.
- The Board's activities and outcomes will be incorporated into existing system governance and reporting arrangements as appropriate.
- Any significant changes to governance arrangements or delegated responsibilities will be brought back through the appropriate ICB governance route for consideration.

6. Appendices

Appendix One: Liverpool City Region Combined Authority Papers Item 11. 6/11/26
[Agenda for Liverpool City Region Combined Authority on Friday, 6th November, 2026, 1.00 pm - Modern Council]

Terms of Reference for Liverpool City Region Health and Wellbeing Partnership Board



Appendix 1 - Establishment of Liver

Annex 1: Draft Terms of Reference for Liverpool City Region Health and Wellbeing Partnership Board

Function / Purpose	Liverpool City Region Health and Wellbeing Partnership Board (PB) is an informal joint committee created by LCRCA, the six LCR local authorities and Cheshire and Merseyside ICB. The purpose is to enable joint work and decision making to improve population health and reduce health inequalities in LCR. This will deliver on: • The Mayor's Health, Wellbeing and Public Service Reform Competency • The LCRCA's duty to have regard to the need to improve population health and reduce health inequalities across the City Region in the exercise of its functions • Marmot City Region and All Together Fairer commitments The focus will be on driving the shift towards prevention and early intervention including by: • Joining up health and other public services, including at neighbourhood level, to improve access and outcomes. • Supporting the operation of LCRCA's 'health in all policies' approach • Strengthening alignment between local government and ICB commissioning and developing a preventative whole system approach to funding flows and investment decisions. The PB will agree joint priorities and an aligned workplan. It will also provide a forum for joint consideration of our responses to and implementation of relevant future policy and legislative changes.
Advisory	Collaboration / advisory with recommendations made to the LCR Combined Authority and ICB as necessary for formal agreement.
Interactions	Collaboration through this PB is intended to provide a clear interface between LCRCA Public Service Innovation Portfolio Board and the ICB and compliment and augment the work of the following partnership structures: • The six Health and Wellbeing Boards • The CHAMPS Public Health Collaborative Board The PB will not replicate existing health system accountability arrangements as delivered through the NHS Oversight Framework.

Chair	The PB will be chaired by the Cabinet Member for Public Service Innovation at LCRCA and the Chair of Cheshire and Merseyside ICB will be the vice chair.
Membership	Local government members: • 6 cabinet members, with alternates identified • Combined Authority Health Commissioner (if appointed) NHS Members: • ICB Non-Executive Director • ICB primary care partner board member • Acute Hospital Board Chair • Mental Health Board Member • Chair of Alder Hey Lead officers of core partners: • Executive Director of Public Sector Innovation, LCRCA • CEO of Cheshire and Merseyside ICB Statutory Officers • Lead LA Chief Exec and (also Partner Member of the ICB Board) • Representative DPH • Representative DASS • Representative DCS • Representative Growth Director • Representative S.151 Officer • Commissioning Lead ICB • Director of Population Health ICB • Other supporting officers in attendance as required Key external representatives • VCFSE Representative • Overview and Scrutiny Chair
Quoracy	One third of the local authority and combined authority representatives and one third of the health system representatives
Meeting Arrangements	Quarterly at 1 Mann Island, Liverpool L3 1BP Meetings will be held in private with minutes published (subject to the same exemption criteria that apply to local government statutory meetings)
Lead contact	[TBA]
Date ToR Approved	[To be at the date of the first meeting]

Meeting of the Board of NHS Cheshire and Merseyside

26 November 2026

Report of the Chief Executive

Agenda Item No: ICB/11/26/26/15

Responsible Director: Liz Bishop, Chief Executive

REPORT SUMMARY SNAPSHOT

Required Information	Details				
Responsible Executive Director	Liz Bishop – Chief Executive				
Report approval	**By**	Liz Bishop – Chief Executive			
	Date	26 November 2026			
Presented by	Liz Bishop – Chief Executive				
Ask of the Board	**Approval**			**Decision**	
	Endorsement			**Ratification**	
	Receive assurance	✓		**Note**	✓
Route to Board – where has this report been discussed	N/A				
ICB Strategic Objective(s) the report relates to	**Tackling Health Inequalities in access, outcomes and experience**	✓		**Improving Population Health and Healthcare**	✓
	Enhancing Productivity and Value for Money	✓		**Helping to support broader social and economic development**	✓
Board Assurance Framework Risk(s) the report relates to*	P12 – Failure to reduce health inequalities and improve population health P14 – Failure to recover access and performance standards				
Financial Implications*	**Yes**			**No**	✓
	If Yes:				
	Have the financial implications been reviewed by the Director of Finance				N/A
	Has a budget been identified				N/A
Legal Implications*	N/A				
Conflicts of Interest associated with this report	N/A				
Impact assessments undertaken*	**Equality**				N/A
	Quality				N/A
	Data				N/A
	Sustainability				N/A
Public or Clinical engagement undertaken	N/A				

Report of the Chief Executive (November 2026)

1. Introduction

1.1 This report highlights of work progressed by the Integrated Care Board at a senior level and also key developments in health and care for Board information. Items covered here are 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;
- **note** the decisions taken by the Executive Committee
- **disseminate** and cascade key messages and information as appropriate.

3. Key Updates

3.1 NHS England Annual Assessment 2025-26

NHS England's Annual Assessment of NHS Cheshire and Merseyside's performance in 2025-26 presented a balanced picture of progress in a number of priority areas, while also recognising continuing challenges – particularly in urgent and emergency care.

The annual assessment letter recognised stronger governance, strategic commissioning capability, partnership working and community engagement across the system.

Elective recovery was identified as a major strength, with the Cheshire and Merseyside Provider Collaborative outperforming plans on key referral-to-treatment targets and maintaining strong diagnostic performance.

The system was also credited for demonstrating increased maturity in population health management and reducing health inequalities, including via initiatives such as All Together Fairer and greater use of population health intelligence.

3.2 All Together Smiling and Mini Mouth Care Matters

NHS Cheshire and Merseyside has approved plans to continue and expand All Together Smiling - our supervised toothbrushing programme focused on reducing oral health inequalities.

Since launching in April 2024, the programme has supported around 18,400 children within the 20% most deprived areas in our subregion, through supervised toothbrushing across 359 settings, and the distribution of over 451,000 oral health packs. The next phase of the programme will see support expanded for children and young people attending specialist Special Educational Needs and Disabilities (SEND) settings, helping ensure even more children can benefit from accessible, inclusive oral health support tailored to their needs.

The Mini Mouth Care Matters programme, currently in place at Alder Hey Children's NHS Foundation Trust, will also be expanded into children's wards across district general hospitals throughout Cheshire and Merseyside. The initiative is designed to improve the oral health of children and young people during hospital admission. It helps healthcare teams incorporate oral health assessments and good mouth care into everyday hospital care, ensuring that opportunities to identify unmet oral health needs and provide support are not missed.

Families, schools and childcare providers across Cheshire and Merseyside have already highlighted the difference that consistent oral health support can make. Their experiences are showcased through a range of case studies and videos available on the NHS Cheshire and Merseyside website, while information and resources about Mini Mouth Care Matters can be accessed through the Alder Hey Children's NHS Foundation Trust website.

3.3 'Future-focused prevention' report showcases the impact of prevention across Cheshire and Merseyside

NHS Cheshire and Merseyside's Director of Population Health, Professor Ian Ashworth, has published his 2025/26 Annual Report, highlighting the role of the NHS in preventing ill health, reducing health inequalities and improving population health.

The report, 'Future-focused prevention', showcases examples of work taking place across Cheshire and Merseyside to embed prevention into healthcare services, alongside recommendations for how organisations can build on this progress. The report is also accompanied by a film which brings a range of powerful stories to life. the publication comes as the NHS continues to focus on shifting from hospital to community, analogue to digital, and treatment to prevention, as set out in the Government's NHS 10-Year Plan for England.

The report highlights initiatives demonstrating how prevention can be integrated into NHS services, including work to tackle fuel poverty, support people to stop smoking, identify cardiovascular disease earlier and improve asthma care for children and young people.

In Cheshire and Merseyside, an estimated 450,000 households live in cold or inadequately heated homes, which can worsen respiratory conditions such as chronic

obstructive pulmonary disease (COPD) and asthma. Through a partnership approach, more than 900 patients have been placed on a fuel poverty pathway, connecting them with clinical reviews and practical support. An evaluation estimated a 10% reduction in GP appointments among the patient cohort compared with a control group.

The report also highlights progress through the All Together Smokefree programme, which supports NHS organisations to establish smokefree hospital environments and provide treatment for tobacco dependency. During the reporting period, 16,735 of the 17,735 inpatient smokers identified across Cheshire and Merseyside agreed to be referred to tobacco dependency services.

Other examples include a pilot offering blood pressure checks through 60 opticians, which has delivered 1,243 checks since June 2025, and the 'Too Much Blue – Get a Review' campaign, which has generated 376,000 impressions and 114,000 interactions across social media platforms to raise awareness of asthma management among children and young people.

The report also highlights work to improve NHS staff flu vaccination uptake. Following targeted support informed by insight work with more than 1,500 healthcare workers, the programme resulted in 5,000 additional flu vaccinations compared with the previous year.

Alongside celebrating this work, the report sets out five recommendations for NHS organisations across Cheshire and Merseyside. These include strengthening leadership on prevention, taking a holistic approach to patient care, prioritising support for healthy behaviours, improving staff wellbeing and ensuring healthcare environments promote health. The report also emphasises the importance of working collaboratively across the health and care system to address the wider factors influencing health and wellbeing, prevent illness and reduce inequalities across the population.

3.4 NHS Cheshire and Merseyside selected for first phase of national Steps to Safety programme

NHS Cheshire and Merseyside has been chosen as one of just 12 Integrated Care Boards to take part in the first phase of a new national programme aimed at supporting victims of domestic abuse and sexual violence.

Announced by the Secretary of State for Health and Social Care, Steps to Safety is a groundbreaking national programme designed to strengthen the healthcare response. The programme will support GP practice teams to recognise signs of domestic abuse and sexual violence, respond appropriately and help people access specialist support services within their local communities.

NHS Cheshire and Merseyside is one of just 12 Integrated Care Boards across England to receive phase one funding. The first phase will focus on strengthening partnerships with specialist services and supporting the rollout of specialist training for GPs and practice staff.

Funding for the programme has now been confirmed, with NHS Cheshire and Merseyside receiving more than £1.7m in Phase One. This investment will help strengthen local specialist support services, ensuring more people can access the help they need within their communities.

3.5 Elective care delivery referral to treatment times improve and Integrated Referral Model progresses

Cheshire and Merseyside continues to improve elective care delivery, with 18-week referral to treatment (RTT) performance at 65% (the 13th highest out 42 ICBs in England).

The ICB is also now 11th out 42 ICBs in England and ahead of plan for 52-week performance, with 1.1% of patients now waiting longer than 52 weeks, compared to 4% for the same period last year.

With a focus on further improving RTT performance, work continues to develop the Cheshire and Merseyside Integrated Referral Model, with a go live date planned for October this year. Procurement is underway for an interim solution for the remainder of 2026/27. The first phase of the programme will offer a Single Point of Access (SPOA) for Gynaecology, ENT and Dermatology for all new referrals across the region.

Led by our providers (CMPC), this three-year system-wide programme will provide early clinical triage, advice and guidance and Tier 2 services delivered in the community. In line with national planning requirements, this will help improve access and timeliness of care for patients in the community, whilst helping to safely reduce demand on acute services.

3.6 Collaboration provides faster access to scans across the region

A major digital transformation programme is improving care for patients across Cheshire and Merseyside. Designed to better the way that diagnostic information can be accessed and shared across trusts, the programme is enabling more joined-up care for patients being treated across different NHS organisations.

Historically, access to radiology images such as X-rays, CT scans, and MRI scans has been fragmented, with images stored by individual trusts. Led by CMPC's Cheshire and Merseyside Radiology Imaging Network, acute and specialist hospitals have worked collectively to implement one single high-speed Digital Diagnostics Network (DDN).

This will enable dedicated diagnostics traffic to be managed more effectively across the region, allowing scans to be shared and accessed through one secure system more quickly, reliably and resiliently. Faster access to scans will help to reduce delays in emergency, inpatient and cancer pathways. Other benefits are improved equity of care, strengthened cyber security, enhanced system resilience and a reduced reliance on ageing technology. For patients, one system means that they are less likely to need repeat imaging.

3.7 Cheshire and Merseyside primary care excellence celebrated at RCGP Mersey Faculty Awards 2026

Primary care colleagues and medical students from across Cheshire and Merseyside have been recognised for their outstanding dedication, innovation and contributions to general practice at this year's Royal College of General Practitioners (RCGP) Mersey Faculty Awards.

The RCGP Mersey Faculty Excellence in Primary Care Annual Awards 2026 took place in Liverpool on Friday 6 November, bringing together individuals and teams from across Merseyside, Cheshire and the Isle of Man to celebrate achievements that have made a positive difference to patient care and to the future of general practice.

The awards recognise outstanding general practitioners, practice teams, members and medical students who have demonstrated excellence within primary care.

Among those recognised were:

- **Dr Randir Noorpuri**, winner of the **GP Award**
- **Dr Cecilia Vinchenzo**, Mersey Faculty Registrar Lead, winner of the **GP Registrar Award**
- **Great Sutton Medical Centre**, Ellesmere Port, winners of the Practice Team Award
- **Bryony Joyce, Earnswood Medical Centre**, Crewe, winner of the **Team Member Award**
- **Dr Kishor Vithlani FRCGP**, winner of the **Provost Award** for his continued support of medical students and services to the faculty

Medical students were also recognised through the annual poster prize competition, celebrating research, innovation and ideas which could help shape the future of healthcare.

The **Poster Prize** winners were:

- **1st place: Josiah Wilson** (University of Liverpool) for *Is AI the solution, and how will we know?*
- **2nd place: Naina Bhasin** (University of Liverpool) for IBS: *To what extent is medical misogyny leading to incorrect diagnoses in practice?*
- **3rd place: Miloni Das** (University of Liverpool) for *Triple-Whammy Prescribing: Findings from a UK general practice.*

Highly commended entries were awarded to:

- **Ayesha Haj Ibrahim** (Edge Hill University) for *Integration of Arts-based Interventions into the Medical Curriculum.*
- **Azizjon Hudoyberdiev and Esra Ramadan** (University of Liverpool) for *Concern is universal, but is the burden: remote primary care consultations for patients with and without long-term conditions.*

- **Georgie McKenzie** (University of Liverpool) for *Management of PCOS in primary care: An audit of a GP*

Congratulations to all winners, highly commended entrants and finalists whose achievements showcase the talent, innovation and dedication of those working and training in primary care across Cheshire and Merseyside.

4. Executive Committee Activity

Covering meetings 17 September, 1st October, 15 October and 2nd November

4.1 Purpose

This report summaries the significant business considered, key decisions taken, and risks identified by Executive Committee between September and November 2026 to support.

4.2 Overall Themes

During the period, Executive Committee's agenda covered a number of key themes:

1. Strategic Commissioning and Contracting

The Committee oversaw development of the 2027/28 commissioning intentions framework, with an emphasis on:

- Neighbourhood health and integrated community services.
- Prevention and population health improvement.
- Strategic commissioning rather than provider-led investment requests.
- Alignment between commissioning, contracting and financial planning.
- Contractual mechanisms to support transformation and performance improvement.

The Committee also reviewed future commissioning models for specialist and delegated services, including Individual Funding Requests and SEND commissioning arrangements.

Key Decisions

- Greater Manchester-hosted Individual Funding Request service model.
- Revised Working with People and Communities Strategy for onward Board approval.
- SEND Expert Hands Programme commissioning arrangements.
- Commissioning intentions and contracting approach for 2027/28.

2. Quality, Safeguarding and Provider Oversight

The Committee maintained oversight of quality and safeguarding matters across a number of providers. Issues considered included:

- Safeguarding governance.
- Organisational culture and quality concerns.
- Contractual assurance arrangements.
- Learning arising from the Thirlwall Review.
- Health outcomes for children and young people.
- Health assessments for children entering care.

3. Urgent and Emergency Care and Performance Recovery

Urgent and Emergency Care remained an operational risk discussed across meetings which included committee consideration of:

- Winter resilience and operational preparedness.
- Referral to Treatment (RTT) recovery trajectories.
- Urgent Treatment Centre developments.
- Same Day Emergency Care schemes.
- Contract performance management.
- Provider recovery plans.
- Delivery of activity versus treatment outcomes.

Key Decisions

- Issue of Activity Query Notices to six providers where activity growth was not translating into RTT improvements.
- Reclassification of £750k Single Point of Access funding to support urgent care transformation.
- Progression of urgent care transformation planning aligned to neighbourhood models.

4. Financial Sustainability and Investment Decisions

Reviewed financial performance, efficiency programmes and investment requests throughout the period including:

- ADHD and neurodiversity demand growth.
- Prescribing expenditure.
- Mental health package costs.
- Provider financial sustainability.
- Delivery of recurring efficiencies.
- Return on investment from transformation schemes.

Key Decisions

Continuing Healthcare Fee Reform
Approved implementation of fixed-rate pricing arrangements for Continuing Healthcare nursing home placements across Cheshire to provide for consistency of approach

Medicines Management Investment
Approved continuation of medicines management overtime arrangements to support delivery and financial efficiencies.

Adult ADHD Investment to providers contingent upon receipt of business information

East Cheshire Trust Investment Proposal
The Committee required stronger evidence regarding benefits realisation, affordability and risk sharing.

5. Service Transformation and Population Health

The Committee continued to oversee major transformation programmes designed to support neighbourhood health and out-of-hospital care. Discussion focused on:

- Primary care estate modernisation.
- Community-based care delivery.
- Frailty pathways.
- Falls response services.
- Neighbourhood development.
- Learning disability and autism services.
- Population health improvement.

Key Decisions
Estates Programme

- Progression of the Aintree Primary Care Development Outline Business Case.
- Progression of the Maghull Health and Wellbeing Centre Outline Business Case.

Community and Specialist Services

- Positive Behaviour Support Service redesign.
- Falls Pickup Service redesign programme.
- SEND Expert Hands Programme.

Estates Strategy

- Development of a Cheshire and Merseyside-wide LIFT estate strategy and concession planning programme.

6. Governance, Risk and Organisational Assurance

The Committee undertook regular review of organisational governance and assurance arrangements

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- Corporate Risk Register.
- Board Assurance Framework development.
- Research and Innovation governance.
- Emergency Preparedness and Resilience arrangements.
- Corporate assurance processes.
- Legal and judicial review matters.

Key Decisions
Corporate Assurance - Implementation of the Corporate Assurance Group.

Research and Innovation - Creation of a new Research and Innovation System Oversight Group and governance framework. [Confirmed...tober 2026 | Word]

Emergency Preparedness - EPRR Loggist rota arrangements.

NICE Governance - Enhanced oversight arrangements for future high-cost NICE Technology Appraisals.

4.3 Overall Assurance:

Executive Committee has demonstrated effective oversight of strategic commissioning, provider performance, transformation and organisational governance. The Committee has taken a number of investment and commissioning decisions while maintaining focus on the most significant system risks affecting delivery of the Integrated Care Board's strategic objectives.

5. Appendices

N/A

6. Officer contact details for more information

Liz Bishop
Chief Executive

Laura Cassidy, Senior Business Manager to Chair and Chief Executive, laura.cassidy@cheshireandmerseyside.nhs.uk

NHS
Cheshire and Merseyside

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

26th November 2026

ICB Financial Position – Month 7

Agenda Item No: ICB/11/26/26/16

Responsible Director: Andrea McGee, Executive Director of Finance

ICB Financial Position – Month 7 (October 2026)

1. Purpose of the Report

1.1 This report updates the Board on Cheshire and Merseyside ICB's financial performance as at Month 7 of 2026/27.

2. Executive Summary

2.1 The ICB is reporting a breakeven position at Month 7 and continues to forecast delivery of the planned breakeven position for 2026/27. The overall position includes a number of favourable and adverse variances from budget across individual areas of expenditure, which continue to be actively managed.

2.2 The Cost Reduction and Efficiency Schemes (CRES) programme is reporting a £0.9m adverse variance year-to-date. However, the full £144m CRES requirement has been identified, with schemes totalling £147.5m and a risk-adjusted forecast of £146.4m, £2.4m above plan. CRES continues to be monitored closely, however given the value is a key risk.

2.3 Additionally, key financial risks to delivery of the year-end position are provider activity, Mental Health Packages of Care, prescribing, and ADHD expenditure. These areas remain subject to enhanced monitoring, grip and control.

2.4 The wider Cheshire and Merseyside system is reporting a £38m adverse variance to plan at Month 7, largely reflecting operational pressures and non-delivery of Cost Improvement Plans. While organisations are expected to deliver individual breakeven positions, the overall system financial position remains important to the ICB and wider system sustainability. There remains a focus on plan delivery, exit run rates and underlying financial positions for 2026/27 which will also impact upon planning for 2027/28.

2.5 Work is progressing on the 2027/28 financial plan, including detailed review of expenditure assumptions and development of the £125m initial CRES requirement. Current planning expectations include a flash submission in December, followed by a full submission in early February and completion of the planning round by the end of March 2027.

3. Financial Position as at Month 7

3.1 As per the summary set out in **Table 1**, the ICB is reporting a breakeven position at Month 7. A brief commentary on the key lines of expenditure is also provided below.

Table 1: Month 7 Financial Position

ICB Total	C&M ICB TOTAL - Month 7 Position		
	Budget £'m	Actual £'m	Variance £'m
Acute	2,163	2,163	(0)
Community	479	480	(1)
Mental Health - Contracts	353	360	(6)
Mental Health - Packages of Care	136	147	(10)
CHC	278	268	9
Delegated GP	370	367	3
Delegated Other - DOP	203	180	24
Prescribing	330	337	(7)
Primary Care Other	76	77	(0)
Other Commissioned Services	12	12	0
Other Programmes	19	26	(7)
Reserves	(5)	0	(5)
Specialised Commissioning	495	495	0
Sub Total - Programme Expenditure	**4,910**	**4,911**	**(1)**
Running Costs	25	25	1
TOTAL EXPENDITURE	**4,935**	**4,935**	**0**
Surplus / (Deficit) Plan	*0*	*0*	*0*
Sub Total - Net Surplus / (Deficit) Reported	***4,935***	***4,935***	***0***

- **Acute Services, breakeven:**
  NHS Trusts are reporting a £0.6m favourable variance year-to-date, driven by underspends against elective, diagnostic and drugs & devices. This is partially offset by pressures against urgent & emergency care, and advice & guidance.

  Independent Sector providers are reporting a £0.4m adverse variance year to date. However, activity remains forecast to be delivered in line with agreed annual plans.

- **Community Services (£1m) adverse:**
  Re-ablement budgets are overspent year-to-date, driven by increased expenditure on packages of care in Knowsley and Cheshire. This pressure is partially offset by favourable prior-year underspends within Intermediate Care and Community Equipment budgets.

- **Mental Health Contracts (£6m) adverse:**
  The overspend year to date is due to new market entrants emerging late in 2025/26 and during 2026/27. Indicative Activity Plans (IAPs) have been issued to these providers to manage activity levels for the remainder of 2026/27.

- **Mental Health Packages of Care (PoC) (£10m) adverse:**
  The overspend is driven by an increase in patient numbers (7.4% increase in volume) and higher expenditure on Mental Health inpatient care and Mental Health Act related (s117, MH & LD) placements.

- **Adult Continuing Care (AACC) £9m favourable:**
  Lower than budgeted patient numbers and underspends against Personal Health Budgets, Fast Track PoC, and Funded Nursing care are driving a favourable variance year-to-date.

- **Delegated Primary Medical Services £3m favourable:**
  Primary Care budgets are reporting a favourable variance, driven by a £1.5m one-off benefit brought forward from 2025/26 relating to activity-based payments, including QOF and Minor Surgery. A further £2m in-year underspend has arisen from the national patient list cleansing exercise and activity-based payments remaining consistent with those seen in 2025/26.

- **Pharmacy, Optometry and Dental (POD) £24m favourable:**
  Of the £24m underspend reported at Month 7, £10m relates to 2026/27 dental activity for which there are currently no confirmed contractual commitments. This position is being closely monitored, recognising that it remains early in the financial year and that a proportion of these funds may yet be required as commissioning plans and contractual arrangements are finalised.

  A further £12.0m relates to prior-year adjustments, reflecting actual activity levels that were lower than originally forecast.

- **Prescribing (£7m) adverse:**
  The prescribing position is based on Month 5 data, the latest information available. A year-to-date pressure of £7m is reported at Month 7, reflecting prescribing expenditure above plan. Key drivers include elevated concessionary prices, medicines returning to tariff, and wider prescribing cost pressures. These increases are partially offset by savings across other drug categories.

- **Other Programme (£7m) adverse:**
  The Grip and Control savings target is held within the Other Programme budget; however, delivery is expected to be reflected through underspends across other budget areas.

- **Reserves (£5m) adverse:**
  The adverse variance against reserves is primarily driven by the original profiling of unidentified CRES at the planning stage, together with balance

sheet review savings that have subsequently been recognised elsewhere in the financial position.

4. Forecast Outturn

4.1 Year end forecasts have formed part of the formal reporting to the Finance, Investment, and Contracting Committee with effect from Month 4. This is earlier than would typically be the case and provides greater assurance over grip, control and the robustness of financial reporting.

4.2 The Month 7 forecast outturn remains breakeven, consistent with the ICB's approved 2026/27 Financial Plan.

4.3 Key forecast risks relate to the Contracts and Investment Review CRES, Mental Health Packages of Care, and Prescribing. These budget areas will continue to be subject to active monitoring and management.

4.4 The forecast will continue to be reviewed and refined monthly to ensure emerging risks or opportunities are identified and addressed at the earliest opportunity.

5. CRES Delivery

5.1 The CRES reported as at Month 7 is £0.9m adverse. This reflects the phasing of unidentified savings included in the ICB's original financial plan. All savings have now been identified and are profiled for delivery later in the financial year.

Programme / Workstream	CRES Target (Plan)	Additional CRES Target	Total CRES Target	YTD Plan	YTD Actual	YTD Variance
ADHD	4,216	1,000	5,216	1,453	1,336	-117
Contract and Investment Review	10,953		10,953	2,219	1,544	-674
Digital	1,000		1,000	106	511	405
Estates	2,246		2,246	730	338	-391
Grip & Control	12,500	5,873	18,373	7,102	14,725	7,623
Independent Sector Contract Management	5,000	4,000	9,000	1,844	2,963	1,119
Individual Patient Commissioning	23,794		23,794	10,252	10,959	708
Management Cost Reductions	21,897		21,897	10,856	10,688	-169
Mental Health Redesign	3,611		3,611	1,393	237	-1,156
Planned Care	2,000	3,000	5,000	333	833	500
Prescribing	25,512	22,354	47,866	16,465	23,926	7,462
Urgent & Emergency Care	3,000	2,000	5,000	500	833	333
Unidentified	28,302	-28,302	0	16,510	0	-16,510
Grand Total	**144,030**	**9,925**	**153,955**	**69,761**	**68,896**	**-866**

5.2 The current forecast is £3.5m above plan. When risk-adjusted to reflect current delivery status, this reduces to a forecast of £2.4m above plan.

5.3 Work is underway to develop 2027/28 CRES schemes, with an initial efficiency target of £125m. Fortnightly reporting to NHS England commenced in November and will continue throughout the planning process, ahead of final plans being agreed in February/March 2027.

6. 2027/28 Planning

6.1 Although national planning guidance has not yet been published, NHS organisations are being encouraged to continue planning based on the previously issued three-year framework to 2028/29, with a particular focus on strengthening and refining plans for 2027/28.

6.2 System planning sessions are being convened, with Executive level representation from providers, ICBs, and NHS England regional teams.

6.3 Regional financial planning principles have been shared and include:

- Delivery of planned exit run-rates; and
- Contracts agreed and signed by 31 March 2027; and
- H1 schemes representing a minimum of 40% of the total efficiency requirement, with these schemes expected to be fully developed.

6.4 The key conditions for plan acceptance are:

- Strategic alignment;
- Credible, deliverable and triangulated plans;
- Financial and workforce sustainability;
- Effective risk management and governance; and
- A coherent and responsive system plan.

6.5 Plans will be assessed against the following outcomes:

- Accepted - all requirements met, with no material conditions required;
- Accepted with conditions – requirements are broadly met, but specific areas require further strengthening, for example where triangulation is limited, risks remain unresolved or the impact of proposed actions is not sufficiently evidenced; or
- Not Accepted – material requirements have not been met and further work is required.

6.6 The current key submission dates are:

- 10th December 2026: Flash submission; detailed requirements are yet to be confirmed (16th December in the last planning round)
- Early February 2027: First full submission following feedback (12th February in the last planning round)

- End March 2027: Final agreed plans and closure of the planning round (18th March in the last planning round)

6.7 ICB Senior Responsible Officers (SROs), supported by lead Directors of Finance, have been identified for each of the key expenditure areas. They will coordinate the refresh of 2027/28 planning assumptions and develop recommendations for review by the planning group and subsequent approval by the Executive Committee.

6.8 In parallel, the finance team is meeting with individual budget holders to undertake a detailed review of 2027/28 budgets and planning assumptions, including non-healthcare expenditure such as digital and estates.

6.9 The final 2027/28 plan will be presented to the Board for approval, in-line with the planning timetable outlined above.

7. Cheshire & Merseyside ICS Position

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

7.2 At Month 7 there is a £38m adverse variance to plan. Two providers are reporting adverse variances, largely driven by the impact of operational pressures and non-delivery of Cost Improvement Plans (CIP).

7.3 The financial position of the two providers reporting adverse variances continues to be monitored through NHS England oversight arrangements. The ICB will continue to assess any consequential impact on delivery of system priorities, activity trajectories and the development of sustainable plans for 2027/28.

8. Risks and Mitigations

8.1 The key financial risks at Month 7 are as follows:

- Elective activity: Provider plans, including Independent Sector, do not deliver the required RTT improvements, potentially requiring additional activity and associated funding to achieve plans.
- Non-Elective activity: Over-performance exceeds the level provided for within contingency, creating a financial pressure.
- Prescribing: Cost pressures arising from concessions and drug tariff increases continue at or above the levels seen year-to-date.
- AACC/MH & Complex Packages of Care: Expenditure may exceed local planning assumptions because of increased patient complexity, demand and price inflation.

- ADHD: Expenditure continues to grow due to increase in demand, including greater use of IS providers through Right to Choose.
- CRES: There remains a risk that schemes do not deliver the required efficiencies in the second half of the year, resulting in a shortfall against the overall CRES requirement.

8.2 Mitigating actions are in place across these areas. These include strengthened grip, control and oversight of the CRES programme, alongside enhanced contract management and performance oversight. Focus is being maintained on activity, expenditure run rates and delivery against forecast, enabling emerging pressures to be identified and addressed at the earliest opportunity.

8.3 The ICB is no longer subject to Financial Performance Review Meetings (FPRMs) with PwC. This arrangement has been replaced by the ongoing regulatory and financial oversight arrangements led by NHS England.

8.4 The Finance Committee continues to undertake detailed reviews of key areas of financial risk and associated mitigations.

8.5 The impact of these risks and mitigating actions on the forecast outturn will continue to be assessed throughout the remainder of the year, with material movements, changes in risk exposure and emerging pressures reported through the Executive Committee, Finance Committee and Board.

9. Recommendations

9.1 The Board is asked to:

- Note the ICB's breakeven position at Month 7 and forecast delivery of the planned breakeven position for 2026/27;
- Note the Month 7 ICS financial position and associated pressures;
- Note the CRES position, including the risk adjusted forecast of £146.4m against the £144m annual plan requirement;
- Consider the key financial risks highlighted within this report; and
- Note progress in developing the 2027/28 financial plan and CRES programme, including the emerging timetable and governance arrangements.

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Meeting of the Board of NHS Cheshire and Merseyside

26 November 2026

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

Agenda Item No: **ICB/11/26/26/17**

Committee Chair: **Sue Lorimer**

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

Committee Chair	Sue Lorimer
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	17th September and 22nd October 2026

Key escalation and discussion points from the Committee meetings

Alert

Month 5 & 6 ICB Financial Position & Forecast Outturn

The ICB continued to report delivery of a break-even position at Months 5 and 6. However, material pressures remain in Mental Health contracts (ADHD), Mental Health packages of care (PoC), and GP prescribing.

ADHD expenditure remains difficult to control as new independent providers can undertake activity before the ICB is aware. IAPs have been developed and issued to these providers to manage activity levels during 2026/27 and mitigate risk to the forecast outturn. Contract management for existing ADHD providers is operating effectively and a new specification is being developed to help manage the risk of new market entrants.

Overspends against Mental Health Packages of Care are driven by higher than budgeted patient numbers and an increase in the average package costs, both running approximately 2-3% higher than planning assumptions.

The committee has requested a detailed report to its next meeting, setting out the underlying drivers of expenditure growth and assurance on the effectiveness and deliverability of the ICB's recovery and mitigation plans.

A deep dive into prescribing expenditure confirmed that the overspend is being driven by factors outside the ICB's direct control, such as no cheaper stock obtainable. Despite these pressures, the ICB's CRES programme remains rated green with savings year-to-date ahead of plan.

Underspends in Primary Care dental services were offsetting most of the overspends. The Committee agreed that wherever possible dental funding should be used for dental services.

To strengthen financial oversight and assurance, a year-end forecast position has been introduced from Month 4 onwards. The forecast remains at break-even at Month 6, with risks consistent with those described above. Forecasting capability will continue to be refined and used to drive corrective action where adverse trends emerge.

CRES Delivery

CRES delivery is ahead of plan YTD (£2.2m), delivery risk remains as 62% of savings are dependent on schemes scheduled to deliver on the second half of the year. Contract and investment reviews are delayed which may restrict the ability to release savings in 2026/27.

The committee continues to monitor progress at scheme level, and deep dives are taking place monthly, targeting high-risk areas.

Work on the current programme is being balanced with the need to identify recurrent savings opportunities for 2027/28, including actions requiring early contractual notice or operational change.

Contract and Activity Management

A number of providers have exceeded planned activity levels which, when triangulated with financial and operational performance, has highlighted unusual activity patterns. Activity Query Notices have been issued and the ICB is working with providers to understand the differences, resolve any data or activity issues, and ultimately maximise performance across the system.

Estates Strategy

The Committee considered the implications of LIFT concession arrangements beginning to expire from 2029. There remains uncertainty regarding future ownership, funding and operational responsibilities, and limited national guidance is currently available.

A Cheshire and Merseyside-wide engagement event has been proposed to establish a shared understanding of the risks and options. The Committee requested a further update within three months, focusing on LIFT buildings, progress against the 2023–2028 Infrastructure Strategy and opportunities to generate efficiencies from the corporate estate.

System Financial Risk

A System-wide financial deficit of c£32m is reported at Month 6, driven largely by industrial action cost and impact on activity income, and CIP under-delivery. This is an in-month deterioration of £7m which is accounted for by a single provider.

Advise

Deconstructing Block Contracts (DtB) for Mental Health and Community

The final national deconstruction returns covered 12 NHS providers and four independent sector providers, with approximately 97.5% of contract income validated and attributed. NHSE indicated that Cheshire and Merseyside had made greater progress than many other systems.

The exercise has nevertheless identified significant differences in provider data quality, activity recording, local pricing and the ability to explain existing contract values. A principal unresolved issue is the national assumption applying a 14.6% productivity deflator to nationally priced activity.

The Committee recognised that moving from block contracts towards more transparent activity-based arrangements will be a multi-year programme. This will require consistent service specifications, agreed counting rules, improved data quality and careful management of the financial impact on providers. It remains uncertain whether the outputs will be used to determine payment arrangements for 2027/28.

Specialised Commissioning

Month 6 specialised commissioning expenditure was reported in line with plan. However, members challenged the apparent alignment of financial performance with budget despite visible provider-level activity variances.

Historic block arrangements mean that activity variation is not yet fully reflected in financial reporting. Further reconciliation is underway before quarterly financial adjustments are introduced. The Committee requested a clearer presentation of provider variances, underlying financial risks and the impact of variable activity, including chemotherapy, diagnostics and urgent and emergency care.

MB undertook to meet with IL to discuss possible improvements to the way the financial information is presented.

Planning for 2027/28 has commenced, with potentially significant national tariff changes anticipated for chemotherapy, transplant services and critical care. The Committee also requested greater clarity regarding the governance of specialised commissioning, the Office of Pan ICB Commissioning (OPIC).

Capital Schemes and revenue consequences

National guidance has increased the threshold requiring a formal ICB letter of support for capital schemes from £1 million to £2.5 million. This is expected to reduce the number of schemes requiring formal endorsement from more than 40 to approximately 13.

The Committee welcomed the reduction in administrative burden but highlighted the potential loss of visibility over associated revenue consequences. Programme leads and contract-management arrangements will therefore need to identify schemes that create ongoing staffing, maintenance, utilities or service-delivery costs, even where these fall below the revised capital threshold.

Primary Care Commissioning Reform

The review of Local Enhanced Services continues, with implementation of a redesigned framework anticipated from April 2028. The review is intended to reduce unwarranted

variation, align services with population health and neighbourhood priorities and establish a more coherent and sustainable commissioning framework.

The Committee emphasised the need for robust financial modelling, continued engagement with practices and Local Medical Committees, and careful consideration of the effect of service redesign or decommissioning on practice sustainability and primary care capacity.

Voluntary, community, social enterprise and faith sector expenditure

The contracting and budget deep dive identified approximately £137 million of 2025/26 ledger expenditure across 143 voluntary, community, social enterprise and faith organisations, compared with £47.8 million identifiable through contract records.

The difference largely reflects zero-value contracts and expenditure recorded directly through the ledger, particularly in Continuing Healthcare. The Committee noted that the absence of a nationally agreed classification for VCSE organisations limits the precision of the analysis.

Members agreed that further work should focus on defining the future strategic role of the sector in neighbourhood health, prevention and community-based provision, supported by improved data quality and the developing Memorandum of Understanding with VCSE partners.

Assure

Exit from Financial Performance Recovery Meetings

Following the successful Month 4 Financial Performance and Recovery Meeting, the ICB has received formal confirmation that it will no longer be subject to the FPRM process.

The Committee welcomed this as a significant achievement, reflecting increased confidence in the organisation's financial management, forecasting, governance and engagement with providers. Remaining PwC involvement is expected to be limited to supporting oversight of the Mersey and West Lancashire Teaching Hospitals taper arrangements.

Independent Sector expenditure

The Independent Sector CRES programme remains ahead of target and is currently assessed as presenting a low delivery risk. Year-to-date expenditure had reduced by approximately 17%, activity by 19% and referrals to independent sector secondary-care providers by around 56%.

The improvement was attributed to stronger contract management, engagement with primary care, development of NHS capacity and introduction of alternative referral pathways. Activity Query Notices and Activity Management Plans are being used where providers exceed agreed levels.

The Committee commended the contracting and commissioning teams and requested that learning from this programme be applied to ADHD, mental health and other areas where new providers are entering the market.

Procurement and Contracting

By October, 24 healthcare and 19 non-healthcare procurement decisions had been completed against the annual procurement plan. Overall delivery remained broadly on track.

In September, the Committee approved publication of the 2025/26 procurement decisions to meet the statutory deadline. Work is continuing to streamline direct awards and contract extensions and to strengthen delivery of the remaining procurement programme.

Patient Transport Services

A new procurement process for patient transport services is underway following the decision to discontinue the previous procurement. Market engagement commenced in October, with tender activity expected to follow.

Given the mobilisation period required for a replacement service, a 12-month extension of the existing arrangements is anticipated. The Committee also noted concerns regarding capacity, discharge delays and patient flow. Further work is underway with the provider collaborative to review demand, capacity, eligibility criteria and future commissioning requirements.

Wirral Same Day Emergency Care Village

The Committee approved the submission of an ICB letter of support for the proposed Same Day Emergency Care Village at Arrowe Park Hospital. The proposal had been reviewed by commissioning and finance teams, endorsed by the Executive Committee and was not expected to create a direct revenue impact for the ICB.

The Committee supported the anticipated operational benefits but requested clearer information regarding the expected impact on urgent and emergency care performance and how these benefits will be measured.

Committee Governance and Effectiveness

The Committee approved revised Terms of Reference, strengthening expectations relating to provider level contract reporting, triangulation of finance, activity, quality and performance information, and clearer ownership of financial and operational risks.

The Committee also recognised the need to prioritise oversight of the largest and highest-risk contracts following organisational change and reductions in analytical and contracting capacity.

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**
FC01 Prescribing cost inflation and uncontrollable drug-market pressures (12)	Approved for inclusion in the FICC Risk Register. Continued monitoring of national price concessions, tariff changes and delivery of medicines-optimisation actions.
FC02 Mental health packages of care demand growth (12)	Approved for inclusion. A multidisciplinary review is examining volume, price and pathway drivers, with further proposals to manage the risk requested.
FC03 Failure to deliver Individual Patient Commissioning CRES (12)	Approved for inclusion. Focus remains on amber-rated schemes and dependencies involving procurement, capacity and multi-agency working.
FC04 ADHD and Right to Choose commissioning growth (8)	Approved for inclusion. Contract management and specification work continue, although the pace of market growth and new provider entry remain difficult to control.
FC05 Procurement capacity	Approved for closure, with residual matters to be managed through business-as-usual arrangements.

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
BAF risk P13	The Committee continued to oversee the ICB financial delivery, CRES performance, contract management and value-for-money assurance. Further attention is being given to mental health, prescribing, and the delivery of recurrent savings.

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Financial planning and recovery	Break-even forecast maintained, supported by Month 6 forecasting, run-rate analysis, risk reviews

Service Programme / Focus Area	Key actions/discussion undertaken
	and oversight through the Financial Recovery Group.
Contracting & Procurement	Procurement plans remain broadly on track. Activity Query Notices and Activity Management Plans are strengthening control of provider activity and expenditure.
Strategic Commissioning	Block-contract deconstruction, specialised commissioning reform and the LES review are providing foundations for more transparent and outcomes-focused commissioning.

Meeting of the Board of NHS Cheshire and Merseyside

26th November 2026

Integrated Performance Report

Agenda Item No: **ICB/11/26/26/18**

Responsible Director: **Jude Adams: Interim Executive Director of Strategy and Transformation (Turnaround)**

Integrated Performance Report

1. Purpose of the Report

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

2. Executive Summary

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

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

2.3 The report has been enhanced as part of a wider piece of work to review the metrics, with the aim of providing clear assurance against statutory duties and strategic priorities.

2.4 The design of this report has been amended and aligns closely with best practice and has been made clearer where performance is not achieving plan. The report now also aligns with the ICB's life-course framework.

2.5 Exception reporting now follows best practice, incorporating a 'What, Why, How & When' approach. This is to provide greater assurance for the audience.

2.6 A considerable number of new metrics were recommended for inclusion following discussions with Exec Directors, Non-exec directors and subject matter experts from within the ICB. A working group was established to consider these, and new metrics are now included in the report. Metrics that were suggested but then excluded from the report were done so for various reasons, including the frequency of available data, and whether there is an alternative, dedicated report for a particular metric.

2.7 The metrics included within the IPR are not intended to be exhaustive.

3. Ask of the Board and Recommendations

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

4. Reasons for Recommendations

4.1 The report is sent for assurance.

5. Background

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

Implications and Comments

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

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

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

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

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

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

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

8. Link to meeting CQC ICS Themes and Quality Statements

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

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

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

9. Risks

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

10. Finance

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

11. Communication and Engagement

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

12. Equality, Diversity and Inclusion

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

13. Climate Change / Sustainability

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

14. Next Steps and Responsible Person to take forward

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

15. Officer contact details for more information

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

16. Appendices

Appendix One: Integrated Quality and Performance report

NHS
Cheshire and Merseyside

Integrated Performance Report

ICB Board

26th November 2026



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Executive Summary

Areas showing improvement

- **Elective recovery continues to make steady progress**, with reductions in both adult and children's 52-week waits. CYP long waits reduced again during September and overall RTT performance remains substantially improved compared with previous years, supported by targeted NHSE recovery funding and system-wide capacity initiatives.
- **Diagnostic performance has improved and remains amongst the strongest nationally**, with Cheshire & Merseyside retaining its position as the highest-performing ICB in the North West and 4th nationally. NHS provider diagnostic performance and endoscopy utilisation continue to improve.
- **Cancer pathways remain a relative strength**, with 62-day performance continuing to outperform England and remaining on track to achieve the year-end ambition, while Faster Diagnosis Standard performance remains above last year's position and is showing signs of recovery.
- **Population health interventions are demonstrating impact**, with six consecutive months of special-cause improvement in smoking prevalence and evidence that targeted breast screening programmes are increasing uptake in previously low-performing populations.
- **Frailty and admission avoidance programmes continue to support system resilience**, with emergency admissions for older people remaining broadly stable and sustained improvement being demonstrated in frailty-related admissions.
- **Organisational performance and provider oversight ratings continue to strengthen**, with a number of Cheshire & Merseyside providers showing improved segmentation and national rankings under the revised NHS Oversight Framework.
- **The ICB remains financially on plan**, reporting a year-to-date breakeven position and maintaining a forecast balanced position for 2026/27.

Areas of concern

- **Urgent and Emergency Care remains the most significant system risk**, with A&E 4-hour performance plateauing below trajectory, 12-hour waits deteriorating further, and performance indicating persistent structural flow challenges across the system.
- **Delayed discharge continues to constrain flow and capacity**, with 21.3% of acute beds occupied by patients no longer meeting criteria to reside, significantly above the system ambition and creating pressure across urgent care pathways ahead of winter.
- **Long waits for children and young people remain a significant challenge**, with 368 CYP patients still waiting over 52 weeks and recovery heavily dependent on Alder Hey Children's Hospital, where 43% of the remaining backlog is concentrated.
- **Diagnostic recovery remains behind plan despite recent improvement**, with performance materially above trajectory, continued endoscopy capacity constraints and substantial underperformance from independent sector providers.
- **Primary care access remains challenged**, with NHS dental access plateauing below trajectory and urgent GP appointments within 24 hours remaining below the improvement trajectory required to achieve year-end ambitions.
- **Population health outcomes remain below ambition**, including cervical screening, MMR vaccination uptake and smoking prevalence, with persistent inequalities across deprived and underserved communities.
- **Cancer Faster Diagnosis Standard below trajectory**, particularly within breast and lower GI pathways, creating risks of delayed diagnosis and onward treatment.
- **Mortality remains a significant quality concern at East Cheshire**, which continues to report SHMI above the expected range, with concerns relating to pneumonia mortality, non-elective admissions & deaths within 30 days of discharge.
- **Financial delivery remains exposed to material risks**, including mental health packages of care, prescribing growth, ADHD demand, non-elective activity pressures and delivery of planned efficiency programmes.

Headlines by life course (1)

Starting Well

Areas of concern

Still birth rates below England average

Smoking in pregnancy reduced supporting improved outcomes

Areas showing improvement

Breast Milk at first feed below national performance levels

Pre-term births continue to be influenced by deprivation and smoking

Growing Well

Areas of concern

CYP elective waits remain above standard

Recovery remains heavily dependent on performance improvement at AHCH

Demand continues to exceed capacity across key paediatric specialties

Areas showing improvement

CYP 52-week waits reduced continuing the recovery trajectory

Additional funding, validation activity & capacity management arrangements continue to support elective recovery

Living Well

Areas of concern

Diagnostic waits remain above trajectory

NHS dental access remains below trajectory

Several providers continue to face operational and capacity constraints affecting elective recovery and long waits

Areas showing improvement

52-week RTT performance close to national standard than in previous reports

C&M ICB remain a strong performer nationally for diagnostics

Headlines by life course (2)

Ageing Well

Areas of concern

A&E 4 & 12 hour performance below trajectory and shows little sustained improvement

High occupancy, discharge delays and constrained capacity reduce system resilience ahead of winter

Areas showing improvement

System wide recovery programmes continue to strengthen operational grip

Frailty and admission avoidance programmes supporting stable emergency admissions in older people

Dying Well

Areas of concern

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

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

Sustained quality improvement action required to address the underlying drivers

Areas showing improvement

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

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

Living Healthy Lives

Areas of concern

Cancer FDS remains below planned trajectory

Cervical screening and MMR uptake below national ambitions

Significant inequalities persist across smoking, screening and vaccinations

Areas showing improvement

Smoking prevalence continues to show special cause improvement

Breast screening programmes are demonstrating positive impact

Cancer 62-day performance outperforms England average

Starting Well

a) Still Birth per 1,000
b) Pre Term births
c) Breast Milk at First Feed

Starting Well

Starting Well - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
Still birth per 1,000 (rolling 12 months) (MSDS)	Year to May 26	2.8	2.6				n/a	3.80	n/a
Pre Term Births	May-26	6.6%	6.0%				n/a	n/a	n/a
Breast Milk at First Feed %	May-26	66.8%	74.0%				n/a	n/a	n/a

Still birth per 1,000

NHS
Cheshire and Merseyside

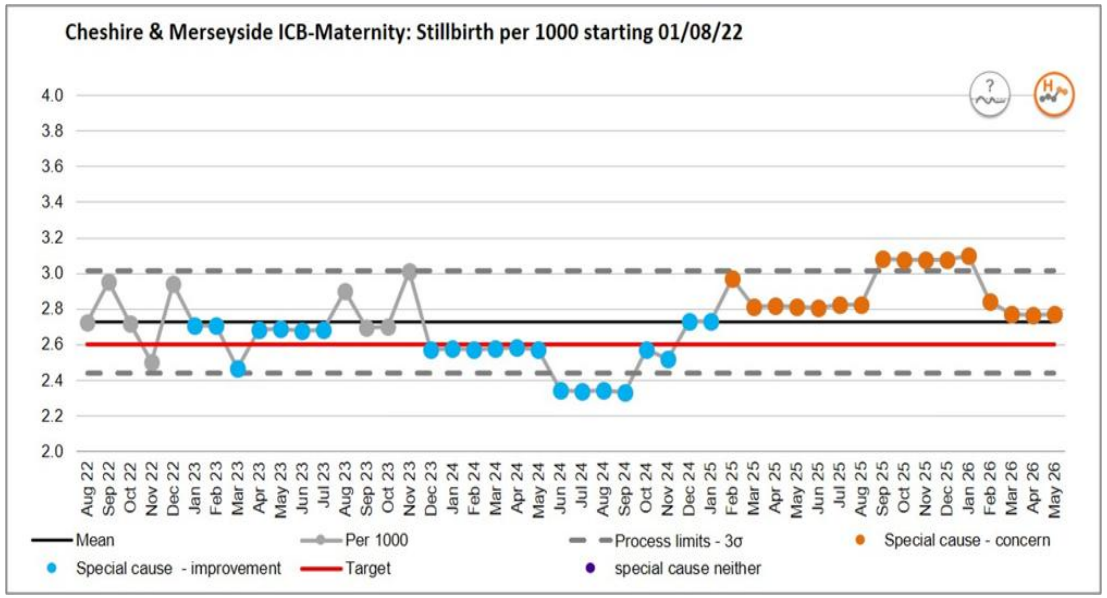
Outcome:

Fewer babies are stillborn, reflecting safer maternity services, earlier identification of risk factors and improved antenatal and intrapartum care.

Measure of Progress:

A decrease in the number if stillbirths per 1,000 total births. The target is 2.6.

Executive Lead: Fiona Lemmens



Still birth per 1,000

1. **The Performance Gap (The "What")**
- This is excluding termination of pregnancy. The C&M stillbirth rate is lower than the England national average.

2. **Root Cause Analysis (The "Why")**
- Occasional increases in rates can be due to spikes which are monitored at provider level
- At ICB level, annual stillbirth reports have identified the following areas for improvement:
- Management of reduced fetal movements and small for gestational age fetuses
- Access to maternity triage. All Providers now invite women in if they phone 3 times and MCHT invite them all in if not happy with advice and have open door policy for women to access Triage.
- Access to translator services for non-English speaking patients
- Difficulties arranging follow up, when care is provided between different organisations

3. **Impact & Risk (The "So What")**
- Stillbirth is an emotionally traumatic experience that deeply affects both parents as well as the wider family
- Reputational damage to maternity care.

4. **Recovery Plan & Trajectory (The "How & When")**
- All Providers over 90% Q4 2025/26 compliant Saving Babies Lives Care Bundle.
- Provider Trust Boards have oversight for MIS year 8 compliance with reporting to NHSE Regional team.
- Annual stillbirth reports published and shared at NW Learning event to raise awareness of regional themes to focus improvement.
- Providers have developed SOPs for patients who do not attend appointments, and Providers implementing NHSE maternity triage framework to improve access.
- Ongoing regional review into management of reduced fetal movements in triage and ultrasound scanning capacity.

Pre Term Births

Cheshire and Merseyside

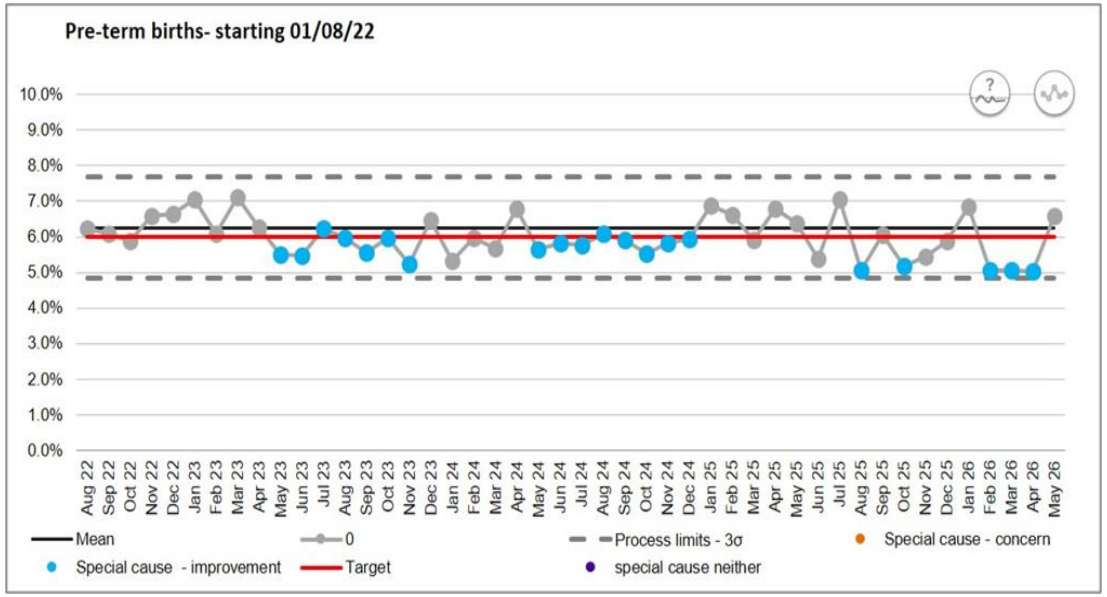
Outcome:

Fewer babies are born preterm, leading to improved health outcomes for infants and families and reducing demand on specialist neonatal services

Measure of Progress:

A decrease in the percentage of live births occurring before 37 completed weeks of pregnancy. The local target is 6%.

Executive Lead: Fiona Lemmens



Pre Term Births

1. **The Performance Gap (The "What")**
- C&M show normal variation around the national average and 6% target.
- C&M measures the clinically important births <34 and <28 weeks which is the area of focus for preterm birth prevention clinics

2. **Root Cause Analysis (The "Why")**
- C&M is more deprived than England average overall, with some of the most deprived local authorities in England, particularly Liverpool, Knowsley, St Helens, Halton and parts of Wirral and Sefton. Deprivation is associated with Preterm Birth
- C&M remains above the average 4.2% for smoking in pregnancy. C&M is currently 4.8% down from 6.5%.

3. **Impact & Risk (The "So What")**
- 7.5% of babies are born preterm and preterm births are a factor in 70% of neonatal morbidity and mortality, with potential for life long negative physical and mental health, social and economic impact on babies and families.
- These risks can be reduced with fetal optimisation prior to delivery, reducing the adverse outcomes for the family, and reducing care required for the infant in the future

4. **Recovery Plan & Trajectory (The "How & When")**
- Regional Guideline for Preterm birth embedded and supported by C+M Preterm birth network
- North West was top performer in 2025 for born in right place which gives best outcomes for Preterm birth as part of optimisation programme
- Over 90% compliant Q4 2025/26 with Saving Babies Lives Care Bundle which includes optimisation elements is still being monitored through Trust Board as part of MIS year 8.

Breast Milk at First Feed

NHS
Cheshire and Merseyside

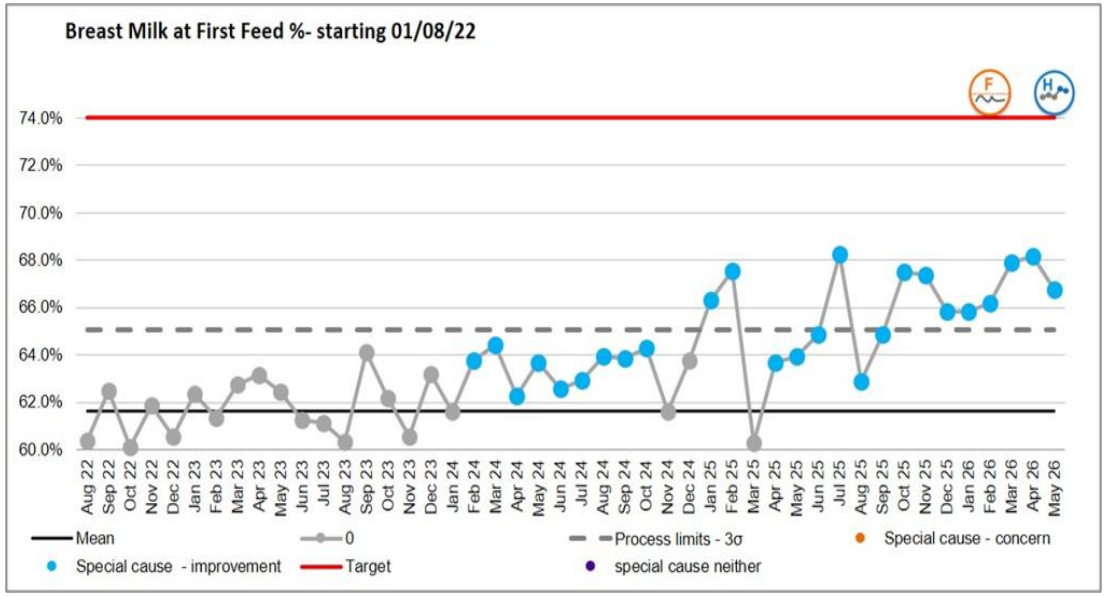
Outcome:

More babies receive breast milk as their first feed following birth, reflecting high quality maternity and neonatal support and improving early life health outcomes.

Measure of Progress:

The percentage of live-born babies whose first feed is breast milk.

Executive Lead: Fiona Lemmens



Breast Milk at First Feed

1. The Performance Gap (The "What")

- Nationally 73-74% of babies receive breast milk as first feed (MSDS).
- Breast milk at first feed provides colostrum (delivering antibodies, immune protection and nutrients that support early adaptation, gut health and infection prevention).
- It is a key quality indicator of maternity care, reflecting successful skin-to-skin contact, early feeding support, mother-baby proximity and the likelihood of establishing ongoing breastfeeding. C&M is now showing special cause improvement but remain below 70%.

2. Root Cause Analysis (The "Why“)

- Breast milk at first-feed data can be affected by: Neonatal unit admissions; Maternal illness; Prematurity; Multiple births; Clinical indications for supplementary feeding; Maternal choice.
- National evidence indicates that breastfeeding outcomes are socially patterned, influenced by deprivation and ethnicity, with lower breastfeeding rates in more deprived populations.
- Variation should be interpreted alongside local demographic factors. C&M is more deprived than England average overall, with some of the most deprived local authorities in England, particularly Liverpool, Knowsley, St Helens, Halton and parts of Wirral and Sefton.

3. Impact & Risk (The "So What")

- Lower breast-milk-at-first-feed rates may reduce babies’ access to the protective benefits of colostrum and are associated with a lower likelihood of establishing and continuing breastfeeding, potentially impacting infant health outcomes.
- At ICS level, low rates may indicate gaps in early postnatal care processes (e.g. skin-to-skin contact, feeding support and mother-baby proximity) and can contribute to widening health inequalities, particularly in more deprived communities.
- Breastfeeding delivers significant health benefits for both babies and mothers, including reduced infant respiratory and gastrointestinal infections and lower maternal risk of breast and ovarian cancer, making it an important population health intervention

4. Recovery Plan & Trajectory (The "How & When")

- Recovery towards the national breast-milk-at-first-feed rate is most likely to be achieved through Providers implementing the C&M Infant Feeding Strategy including improving skin-to-skin contact, supporting breastfeeding within the first hour after birth, reducing mother-baby separation, enhanced support to populations and providers with the lowest rates. Trusts within CM are working towards the UNICEF accreditation programme for infant feeding, one of the key drivers Breast milk at first feed KPI should increase in compliance.

Growing Well

a) 52 week waits for CYP

Growing Well

Growing Well - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
Number of 52+ week RTT waits, of which children under 18 years.	Sep-26	368	0				n/a	n/a	n/a
Number of unique patients seen by an NHS Dentist – Children (12 month)	Sep-26	346,047	338,408				1,060,028	7,414,932	n/a

RTT 52-week waits for CYP

NHS
Cheshire and Merseyside

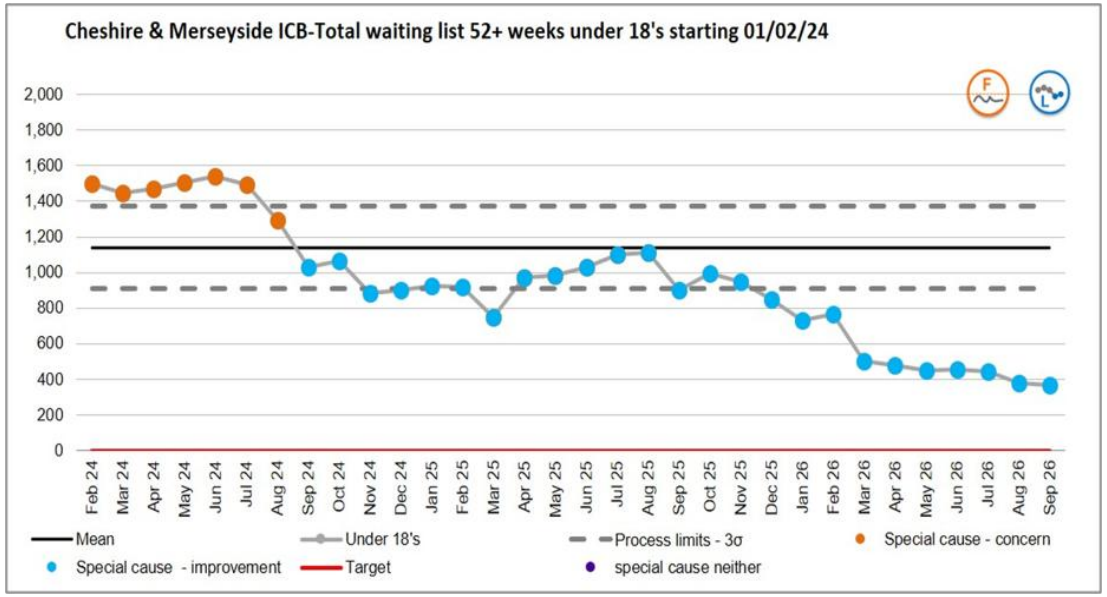
Outcome:

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

Measure of Progress:

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

Executive Lead: Jude Adams



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

1. Performance Gap ("The What")

- 368 CYP patients were waiting over 52 weeks at September 2026 month end, a decrease of 09 patients from the previous month.
- Performance remains above the national standard of zero 52-week waits.
- AHCH accounts for 159 patients (43%) of the cohort, representing the largest area of risk.
- Current recovery activity is not yet reducing the backlog quickly enough to offset new patients reaching 52 weeks.

2. Root Cause Analysis ("The Why")

- Demand in key paediatric specialties continues to exceed available capacity.
- 43% of long waits are concentrated at AHCH, making system recovery heavily dependent on a single provider.
- Workforce and theatre capacity constraints have limited activity growth.
- Specialist paediatric pathways offer limited opportunities for mutual aid across providers.
- Historical data quality and forecasting challenges reduced proactive management of long waits, while validation continues to identify pathways requiring review.

3. Impact & Risk ("The "So What")

- 368 CYP patients remain in breach of the constitutional standard, increasing the risk of delayed treatment and poorer patient experience.
- Continued non-compliance exposes the system to ongoing reputational risk.
- Recovery remains vulnerable due to the concentration of long waits at AHCH and the risk of new patients entering the 52-week cohort.

4. Recovery Plan & Trajectory (The "How & When")

- Six providers remain in the NHS England elective tiering framework with targeted recovery plans and fortnightly CMPC oversight.
- Additional NHSE funding is supporting clinical triage and validation of patients waiting over 27 weeks, delivering 20-30% pathway removals.
- System-wide capacity management and additional regional investment are being used to optimise capacity, increase activity and support inter-provider collaboration.
- Recovery efforts focus on reducing the existing 52-week cohort and preventing new breaches, with progress monitored through established C&M governance forums throughout 2026/27.

Living Well

a) 52-week waits
b) Diagnostics
c) NHS Dentist Adult Access
d) Urgent GP Appointments within 24 hours

Living Well

Living Well - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
The % of people waiting less than 18 weeks on the waiting list (RTT)	Sep-26	66.5%	66.2%	H	F	✓	65.2%	65.9%	16/36
The % of people waiting more than 52 weeks on the waiting list (RTT)	Sep-26	1.3%	0.9%	L	F	✗	1.4%	1.6%	18/36
Patients waiting more than 6 weeks for a diagnostic test	Sep-26	12.1%	7.7%	-	?	✗	14.2%	22.6%	4/36
Number of unique patients seen by an NHS Dentist – Adults (24 month)	Sep-26	959,063	966,320	H	F	✗	2,699,201	18,525,370	n/a
% of urgent GP appointments seen within 24 hours	Sep-26	80.3%	82.0%	H	F	✗	79.0%	77.1%	n/a
Percentage of ICB inappropriate out of area placement bed days in Adult acute beds	Aug-26	1.6%	TBC	L		TBC	1.6%	2.0%	15/36

52-week waits

NHS
Cheshire and Merseyside

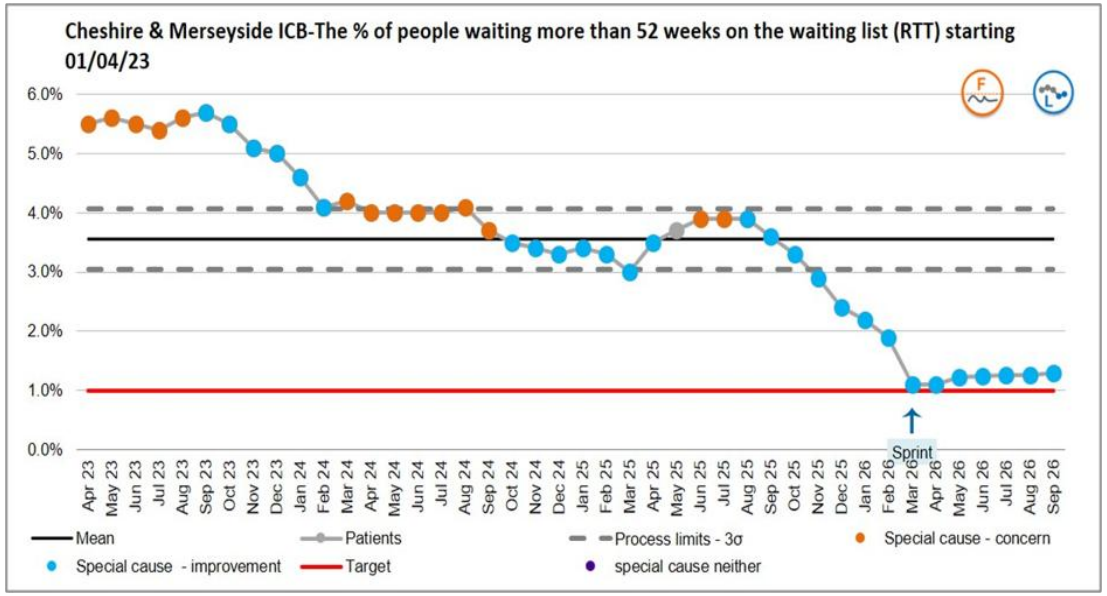
Outcome:

Patients receive planned hospital treatment in a timely manner, with the number and proportion of patients waiting longer than 52 weeks reduced to zero.

Measure of Progress:

A reduction in the percentage of patients on an incomplete RTT pathway who have been waiting more than 52 weeks from referral without starting treatment.

Executive Lead: Jude Adams



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

1. The Performance Gap (The "What")

- Performance remains slightly behind the planned trajectory.
- Despite the shortfall against plan, C&M performance has improved significantly and remains closer to the national standard of less than 1% than in previous periods.
- MWL is currently the most challenged provider while ECT continues to experience performance deterioration following implementation of its trust-wide EPR system.

2. Root Cause Analysis (The "Why")

- Ongoing operational capacity constraints across several providers have limited the pace at which long-waiting patients can be treated.
- ECT has experienced reduced productivity and pathway disruption following deployment of its new Electronic Patient Record (EPR) system.
- Variation in specialty-specific demand, combined with insufficient elective capacity in some organisations, has slowed the reduction of 52-week waiters.

3. Impact & Risk (The "So What")

- Failure to achieve the 52-week RTT standard increases the risk of continued non-compliance with national elective recovery expectations.
- Extended waits can adversely affect patient outcomes, experience & confidence in elective services.
- Continued underperformance may result in increased regulatory oversight, including NHSE tiering, and could impact wider elective recovery trajectories and waiting list reduction plans.

4. Recovery Plan & Trajectory (The "How & When")

- The CMPC Elective Team holds fortnightly review meetings with providers, with escalation processes in place to address emerging risks and delivery issues.
- The C&M Q4 recovery programme, supported by additional NHSE funding, is increasing clinical triage of patients waiting over 27 weeks, achieving 20-30% pathway removals.
- A System Capacity Management Process is being implemented to maximise elective hub utilisation and inter-provider support, while additional regional funding will provide further capacity to reduce long waiters and overall waiting list size during Q4 and beyond.
- Progress will be monitored through the C&M Clinical Operational Group, CMPC COO Group and Delivery Board, with expected trajectory improvement through the remainder of the financial year.

Diagnostic waits >6 weeks

NHS Cheshire and Merseyside

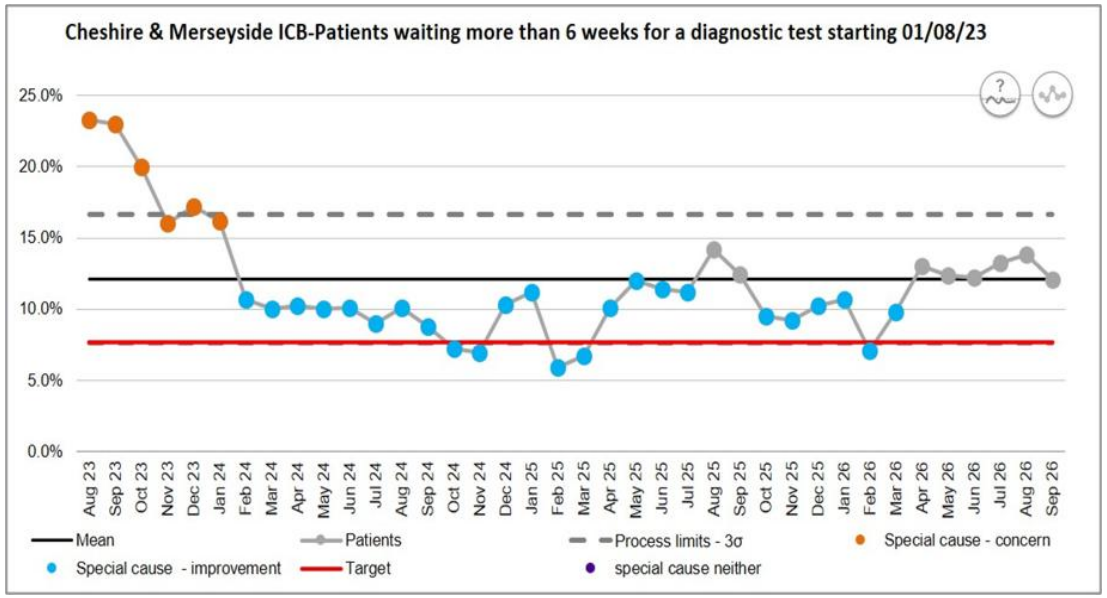
Outcome:

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

Measure of Progress:

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

Executive Lead: Jude Adams



Patients waiting more than 6 weeks for a diagnostic test

1. The Performance Gap (The "What")

- Diagnostic performance position improved during September, 12.1% of patients were waiting more than 6 weeks for a diagnostic test, against a planned position of 7.7%.
- C&M NHS Provider performance has continued to improve as planned from August onwards. As at the latest WLMDS (08/11), 10% of patients are waiting 6+ weeks.
- C&M ICB ranking improved remained stable at 4th nationally, maintaining its position as the best performing ICB in the North West.

2. Root Cause Analysis (The "Why")

- **Independent Sector Providers:** AQP provider performance remains significantly below NHS providers with 25.9% of patients waiting 6+ weeks. Reduced activity plans for 26/27 have resulted in activity being constrained to align forecast outturn with commissioned activity levels.
- **Endoscopy Capacity Constraints:** Endoscopy remains a system wide challenge. However, C&M NHS Provider performance has improved by +12.3% since the beginning of September.
- **MRI Pacemakers:** System provision is extremely vulnerable. University Hospitals North Midlands has closed to referrals from Mid Cheshire Hospitals, whilst Liverpool heart and Chest Hospital has provided notice that external referrals for non-cardiac pacemaker scans will cease from the 27/28 financial year (extended closure date, initially December).

3. Impact & Risk (The "So What")

- **Value for Money:** Independent sector providers contracted through the ICB to deliver tests for NHS funded patients are not demonstrating optimal value for money. Patients are experiencing longer waiting times for tests than those seen within local NHS providers.
- **Patient Pathway Delays:** Longer waiting times for patient diagnosis, increased patient anxiety and poor experience with an adverse impact on cancer and elective pathways.

4. Recovery Plan & Trajectory (The "How & When")

- Independent sector provider underperformance continues to be escalated to ICB contracts team.
- Utilisation of Endoscopy Hub capacity is improving, in August and September 90% of available capacity was utilised by C&M Providers, with a record number of tests delivered in October.
- MRI Pacemaker working group established by the C&M Imaging Network to provide an options appraisal to resolve system service delivery issues and provide sustainable system provision, options for future service delivery are currently being worked through.

NHS Dentist Adult Access

NHS Cheshire and Merseyside

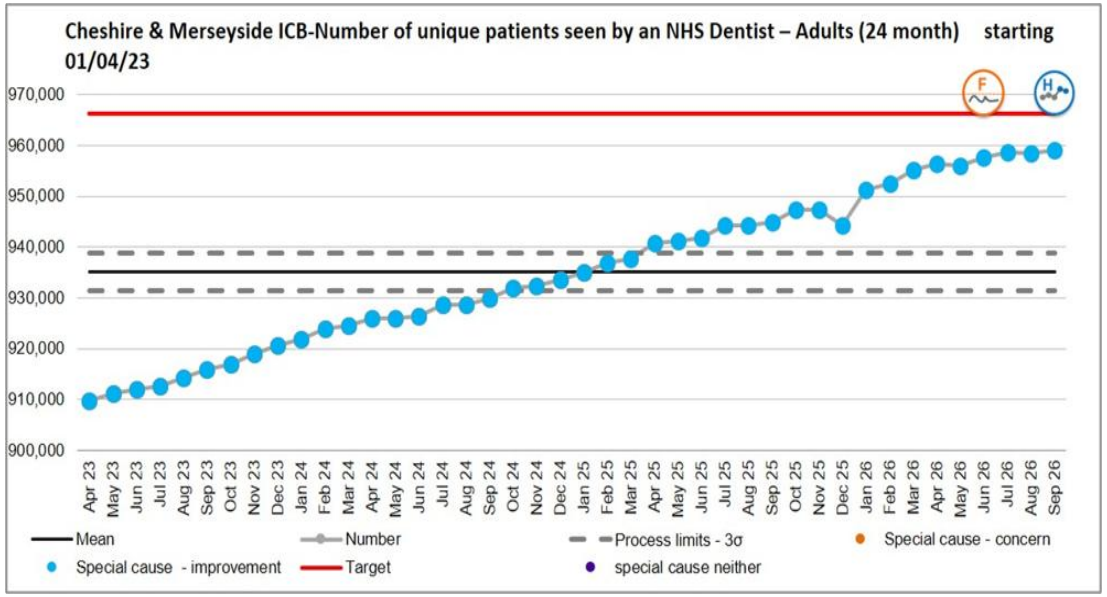
Outcome:

More adults are able to access NHS dental care

Measure of Progress:

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

Executive Lead: Clare Watson



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

1. **The Performance Gap (The "What")**
   - Figures are plateauing and not increasing to meet the target trajectory, over the last few months.

2. **Root Cause Analysis (The "Why")**
   - The national NHS Dental contract reform and activity is not impacting on activity to the desired level.
   - Locally commissioned schemes will not potentially address the core activity required to improve this by the required amount.

3. **Impact & Risk (The "So What")**
   - Dental access continues to be a challenge for patients across Cheshire and Merseyside.
   - Increased number of complaints and patient/external asks for assurance around this from key partners.

4. **Recovery Plan & Trajectory (The "How & When")**
   - The ICB has expanded its local quality/ access scheme for particular groups of patients and targeting practices in our most deprived areas, by a further six months for the remainder of the year
   - The ICB is currently reviewing its approaches to dental improvement for 2027 onwards including options for local commissioning
   - Currently reviewing data and performance in relation to national contract changes to consider impact (Noting the dental contract is agreed nationally not by the ICB)

GP Appointments

NHS
Cheshire and Merseyside

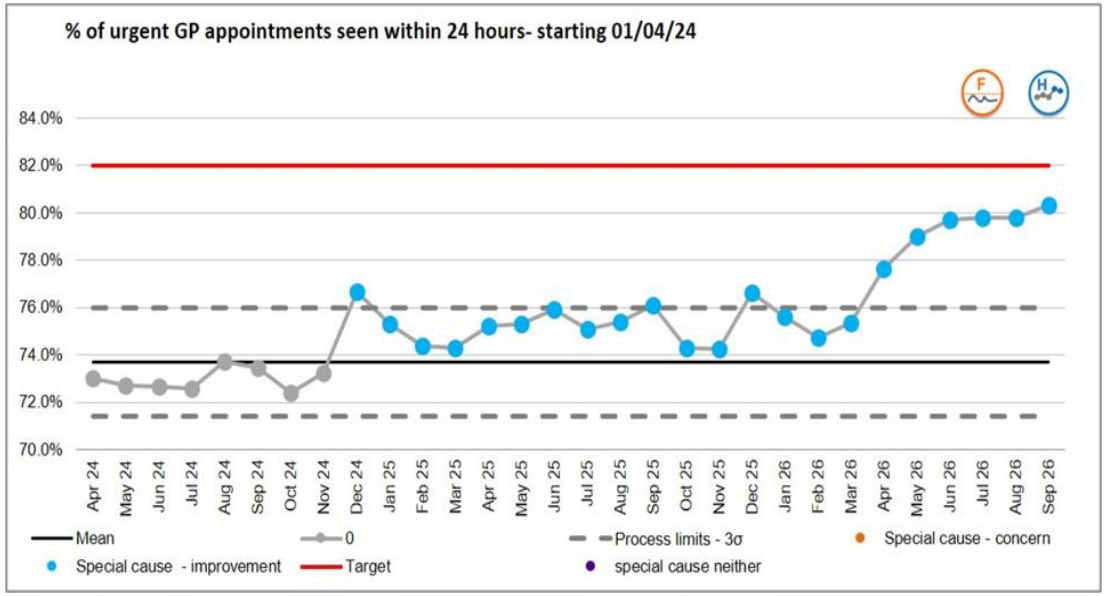
Outcome:

Patients requesting an urgent GP appointment are assessed or seen within 24 hours, ensuring prompt access to appropriate care and reducing the risk of deterioration.

Measure of Progress:

An increase in the % of urgent GP appointments seen, assessed, or contacted by an appropriate clinician within 24 hours. The target is 90% by March 2027.

Executive Lead: Clare Watson



% of urgent GP appointments seen within 24 hours

1. **The Performance Gap (The "What")**
- The ICB has a target of 90 per cent of appointments seen same day by March 2027.
- Current performance 80.3% against a target of 82% – the number has risen since last month (79.8%) but is behind plan trajectory.

2. **Root Cause Analysis (The "Why")**
- The ICB has identified potential issues in specific coding potentially which may be impacting on the overall figure and this is being addressed through further detailed actions.

3. **Impact & Risk (The "So What")**
- The ICB will not meet its target of 90 per cent without further actions.

4. **Recovery Plan & Trajectory (The "How & When")**
- The ICB is reporting, separately, monthly to NHS England and recently presented to them for assurance in this area.
- The ICB has a plan with individual figures and target approaches/further data triangulation to support addressing variation.
- This plan includes practice level data to support in terms of variation in numbers to understand variation reasons and any support that can be offered.
- Note the 90 per cent is not a contractual ask for practices.

Living Healthy Lives

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

Living Healthy Lives

Living Healthy Lives - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Sep-26	74.2%	77.3%	H	?	✗	n/a	70.7%	7/36
Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Sep-26	74.5%	76.8%	H	?	✗	n/a	76.2%	24/36
Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems. (Aged 15+)	Oct-26	15.7%	12.0%	L	F	✗	0.0%	12.7%	n/a
Cervical Screening Rate	Oct-26	68.2%	80.0%	L	F	✗	0.0%	0.0%	n/a
Bowel Screening Rate	Oct-26	70.9%	62.0%	H	P	✓	0.0%	0.0%	n/a
Breast Screening Rate	Oct-26	68.5%	70.0%	L	?	✗	0.0%	0.0%	n/a
MMRV Uptake (2 doses by fifth birthday) (see Note)	Q1 26/27	83.7%	95.0%	L	F	✗	84.1%	82.3%	27/37

Cancer 62-day waits

NHS Cheshire and Merseyside

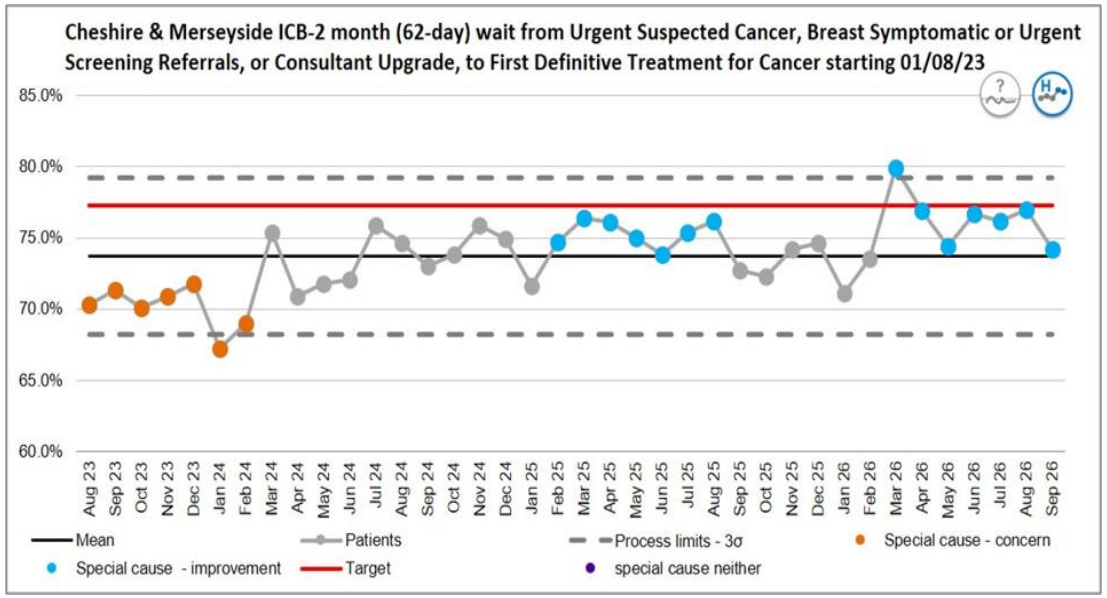
Outcome:

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

Measure of Progress:

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

Executive Lead: Fiona Lemmens



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

Latest Performance	74.2%

1. **The Performance Gap (The "What")**
- C&M is on track to meet the 62-day ambition, outperforming England by 3.5%. Cheshire and Merseyside are positioned 5th against cancer alliances.
- **The figure of 74.2% is below plan for this point in the year, however this follows seasonal Faster Diagnosis Standard (FDS) underperformance, and it is still fully expected that this ambition will be met for the year.**

2. **Root Cause Analysis (The "Why")**
- Challenges to the FDS, particularly for breast and skin, are creating a small onward impact for 62-day which remains far stronger than England on plan. It was anticipated that September data will show a deviation from plan resulting from poorer FDS and this is now apparent. Recovery is expected in October and November.

3. **Impact & Risk (The "So What")**
- The change in performance poses some increased risk but is fully recoverable.
- There is a small risk that patients have experienced increased waiting times and this will affect patient experience as with any deterioration in 62-day.

4. **Recovery Plan & Trajectory (The "How & When")**
- Monthly performance forums will continue throughout 2026/27, with targeted pathway transformation programmes in **lung, skin, gynaecology, breast, and lower GI cancers** supporting further improvements in 62-day performance.
- A radiotherapy improvement plan is in implementation alongside the radiotherapy Operational Delivery Network with funded project management from CMCA, covering workforce and performance.
- Investment of SDF from CMCA for ECT, LUHFT and MWL will directly affect patients in November through to the end of the financial year across Breast, Skin and LGI predominantly.

Cancer 28-day FDS

NHS
Cheshire and Merseyside

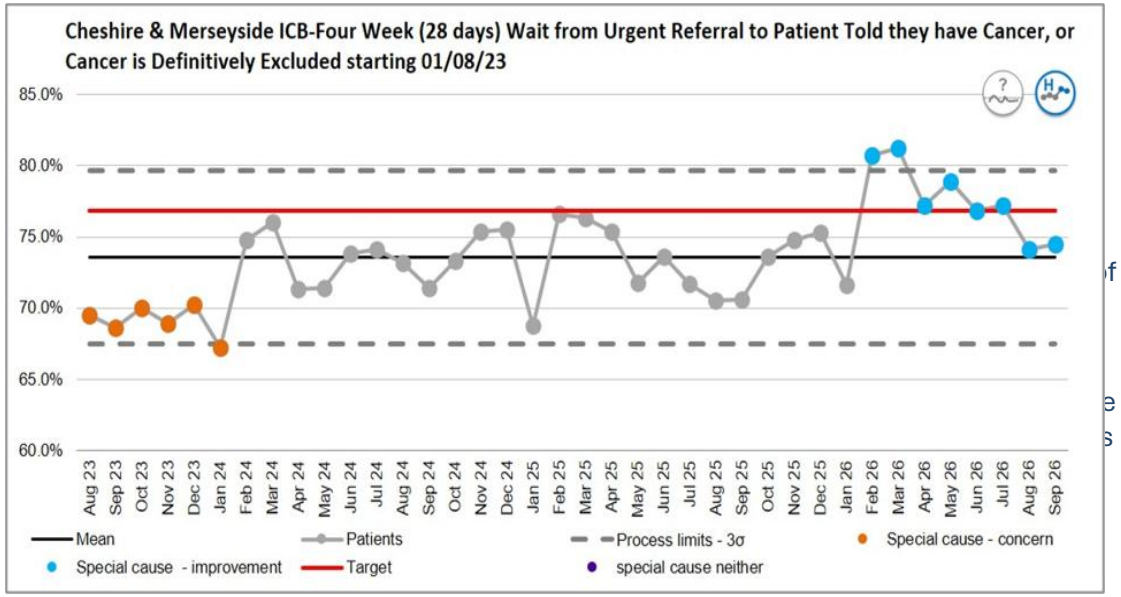
Outcome:

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

Measure of Progress:

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

Executive Lead: Fiona Lemmens



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

Latest Performance	74.5%

1. The Performance Gap (The "What")

- The ICB is currently **3.2 percentage points behind the year-to-date planned trajectory** for the 28-day Faster Diagnosis Standard (FDS).
- C&M continues to be 4.1% higher this year than last year
- C&M is the only system to improve FDS in September, going against the national trend due to positive performance management in skin.

2. Root Cause Analysis (The "Why")

- Positively, seasonal FDS impacts are far reduced in this financial year because of business continuity planning in skin, led by CMCA. The skin peak has now passed and September FDS is improved. October FDS is now 78%.
- However, significant underperformance in high-volume tumour sites has emerged for LUHFT and MWL. These tumour sites are breast and Lower GI with some impact also seen in H&N for LUHFT (though with less impact on the overall system)
- LUHFT is now recovered (80% FDS in October)

3. Impact & Risk (The "So What")

- Continued lower performance in FDS will make it more difficult to recover the average which is the target for the financial year.
- High volumes of patients will wait longer in Breast, Skin and Lower-GI for a ruling out of cancer primarily, and some cancer diagnoses will be delayed, leading to a delayed treatment.

4. Recovery Plan & Trajectory (The "How & When")

- CMCA continues to lead delivery of the FDS through **monthly performance forums with providers**, supporting improvement through pathway transformation, operational oversight, and targeted investment. New investment (£106k for LUHFT and £228k for MWL is focused on rapid recovery of these sites).
- CMCA will now chair weekly improvement meetings with MWL to safeguard delivery of the recovery.

Smoking

NHS
Cheshire and Merseyside

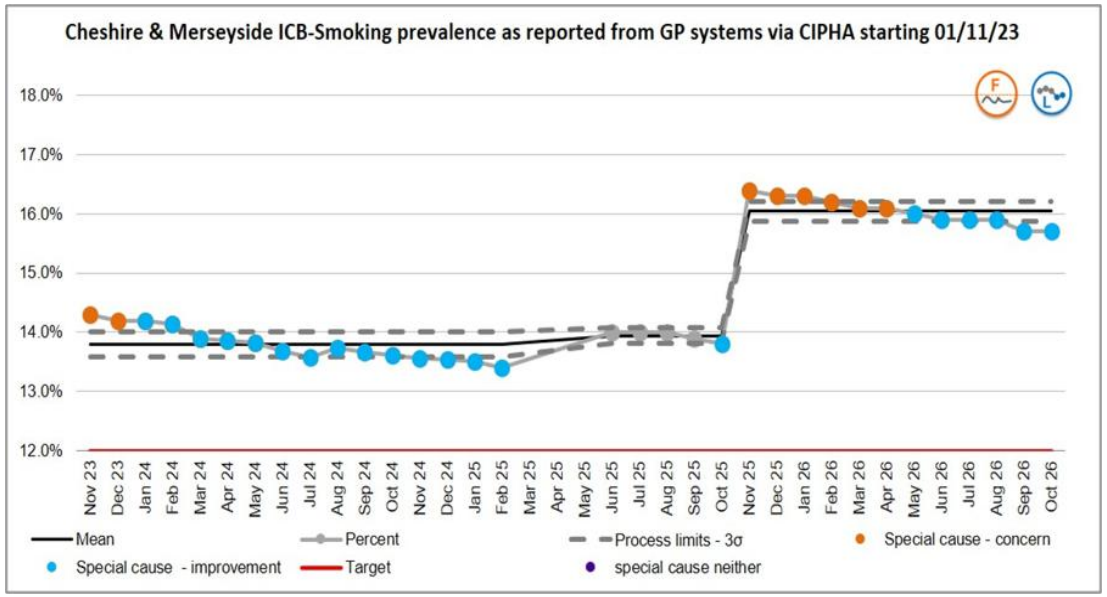
Outcome:

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

Measure of Progress:

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

Executive Lead: Clare Watson



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

1. The Performance Gap (The "What")

- **15.7%** of registered patients aged 15+ are current smokers (Oct 2026) versus a 12% target. The target is not yet met.
- Six consecutive months (May–Oct 2026) show **special cause improvement**, with October below the lower process limit.
- Survey data confirm the trend: In October APS adult prevalence fell to **9.0% in 2025**, below England and the North West; 7 of 9 Places have lower 2023–25 estimates.

2. Root Cause Analysis (The "Why")

- Smoking is concentrated where need is greatest: 1.7 times higher in the most deprived tenth of neighbourhoods; more than a third among people with SMI.
- The GP–APS gap reflects groups under-represented in household surveys and GP smoking status not always being updated after quitting.
- Inconsistent VBA delivery and disconnected pathways limit referrals and quits; process now in place for ATSF System Review actions to be implemented.

3. Impact & Risk (The "So What")

- Smoking remains C&M's leading preventable cause of ill health and premature death, driving cardiovascular, respiratory and cancer demand and widening inequalities.
- Falling headline rates mask high prevalence in priority groups, risking both targets and Living Healthy Lives priorities.

4. Recovery Plan & Trajectory (The "How & When")

- Campaigns are reaching smokers: **53% recalled Hero Wave 1** and over half of those who saw it considered quitting; targeted campaigns generated **1,043 quit attempts** and engaged 8,856 routine and manual smokers.
- **Hero Wave 2** launched 19 Oct 2026 for six weeks (TV, radio, outdoor, digital) with the new Quit 28 support tool.
- NCSCT self-assessment in all local stop smoking services, ICB/Trust pilot in development, and transfer of care pathway reviews.
- Gradual reduction expected through 2026/27; monthly SPC and Place review.

Cervical Screening Rate

NHS
Cheshire and Merseyside

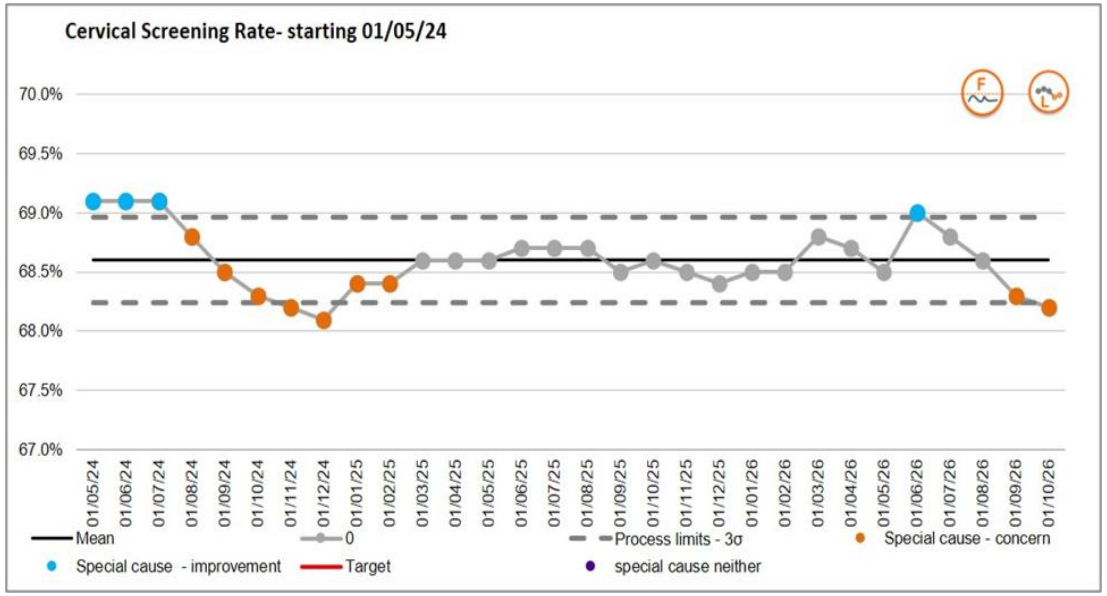
Outcome:

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

Measure of Progress:

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

Executive Lead: Fiona Lemmens



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

Cervical Screening Rate *

1. The Performance Gap (The "What")

- Coverage remains below the national standard, declining from 69.1% in 2024 to 68.2–68.4% in 2026.
- Uptake varies across Places and is lowest in deprived and underserved communities.
- Current interventions are improving access but have not yet raised population-level coverage.

2. Root Cause Analysis (The "Why")

- Deprivation, low awareness, anxiety, cultural factors, previous experiences and practical barriers reduce participation.
- Traditional models, limited appointment flexibility and workforce capacity pressures restrict access, especially for working-age and underserved groups.

3. Impact & Risk (The "So What")

Impact

- Lower coverage reduces early detection and treatment of HPV and cervical abnormalities, widening inequalities and slowing progress towards eliminating cervical cancer by 2040.

Risks

- Uptake inequalities and poorer outcomes may worsen.
- Later detection may increase demand for diagnostic and treatment services.
- Persistent underperformance may increase regional and national assurance scrutiny.

4. Recovery Plan & Trajectory (The "How & When")

- The system-wide CM Cervical Screening Improvement Programme, informed by patient and public insight, targets underserved groups and non-responders.
- Delivery combines community sexual health, workplace, primary care and mobile outreach, supported by NHS, local authority and community partners.
- HPV self-sampling began in August 2026 for eligible people unlikely to attend traditional screening.
- Coverage data lag prevents a definitive recovery trajectory.
- Engagement, uptake and access will track progress, with population-level improvement expected over the medium to longer term.
- The system works with NHS England, schools, providers and primary care to improve HPV vaccination uptake alongside screening and support cervical cancer elimination.

Breast Screening Rate

NHS Cheshire and Merseyside

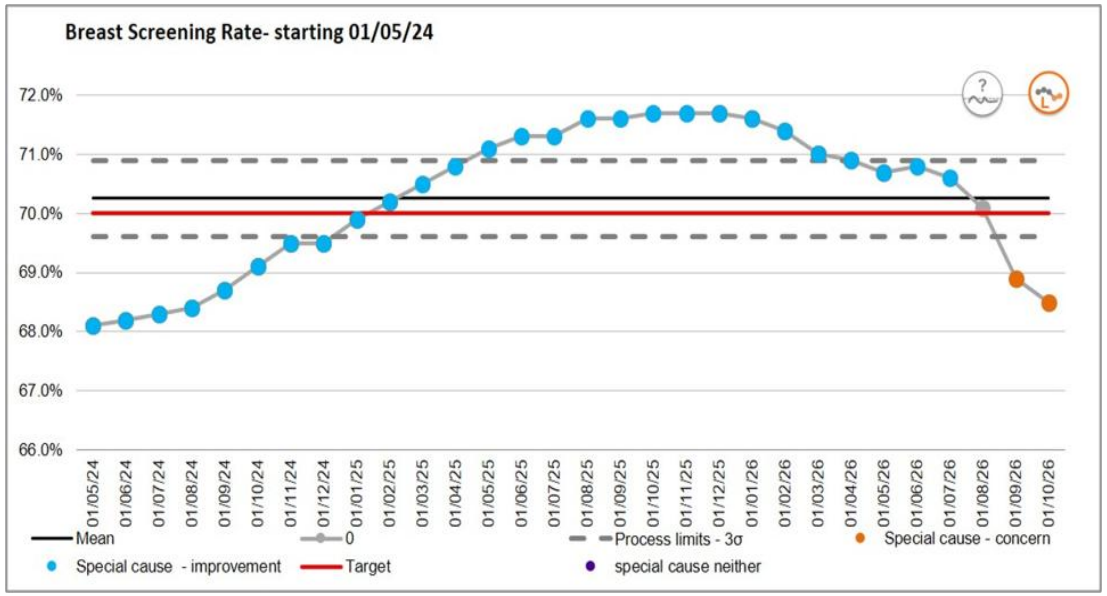
Outcome:

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

Measure of Progress:

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

Executive Lead: Fiona Lemmens



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

Breast Screening Rate *

1. The Performance Gap (The "What")

- Breast screening uptake remains below optimal levels, with performance recently declining towards the target threshold.
- Variation in participation persists across Places and population groups and inequalities in uptake are evident, particularly amongst underserved communities and first-time invitees.

2. Root Cause Analysis (The "Why")

- Lower uptake is associated with health inequalities, underserved populations and first-time invitees.
- Access barriers, including appointment availability and convenience, can influence attendance.
- Patient experience, engagement and awareness continue to affect participation rates.

3. Impact & Risk (The "So What")

- Lower uptake reduces opportunities for early detection of breast cancer and improved outcomes.
- Continued inequalities in attendance may widen health inequalities and result in later diagnosis for some groups.
- Failure to improve participation may place additional pressure on diagnostic and treatment services and impact programme performance.

4. Recovery Plan & Trajectory (The "How & When")

- Whilst changes in uptake may take time to be reflected in reported performance, a range of targeted interventions are in place to increase attendance, reduce inequalities and improve patient experience.
- System-wide breast screening improvement programme established across C&M.
- Dedicated Improving Uptake Workers supporting first-time invitees and populations least likely to attend.
- Expanded access through more flexible appointment options, including early morning, evening and weekend clinics.
- Targeted engagement and communications informed by patient feedback and population health intelligence.
- Strong partnership working across screening, diagnostics and cancer services to support pathway improvements.
- Evidence from the Wirral and Chester Breast Screening Programme, where the lowest-performing practice improved from 43% to 67% uptake, with six of twelve practices now exceeding the 70% acceptable uptake threshold and one exceeding 80%. That gives tangible evidence that the recovery actions are already having an impact.

MMR Uptake

NHS
Cheshire and Merseyside

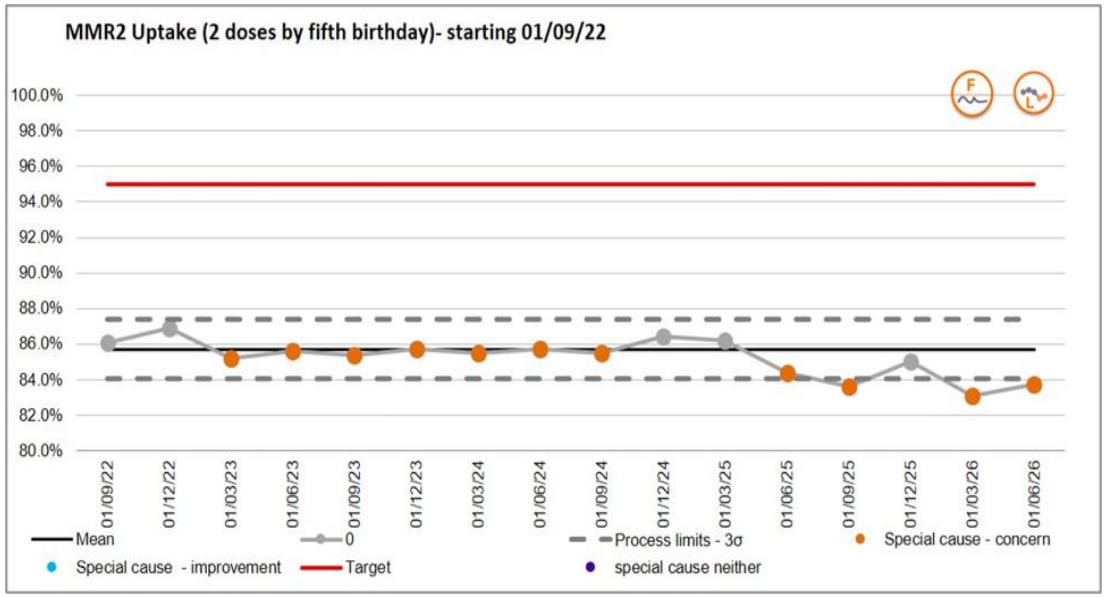
Outcome:

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

Measure of Progress:

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

Executive Lead: Fiona Lemmens



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

MMR Uptake (2 doses by fifth birthday) *

1. The Performance Gap (The "What")

- Two-dose MMR uptake by age five is 84%, below the 95% needed for population protection.
- Coverage remains below target, with marked variation across C&M communities and population groups.

2. Root Cause Analysis (The "Why")

- Lower uptake is concentrated in deprived, mobile and underserved populations facing greater access and engagement barriers.
- Vaccine confidence, awareness and missed opportunities also reduce uptake.
- Previous approaches have not consistently reached children most at risk of remaining unvaccinated.

3. Impact & Risk (The "So What")

Impact

- Coverage below 95% increases outbreak and transmission risk, leaving unvaccinated children vulnerable to serious illness and widening inequalities in underserved communities.

Risks

- Continued underperformance increases outbreak risk and may disproportionately affect communities with lower uptake.
- Outbreak management and further catch-up programmes may require additional healthcare and public health resources and attract greater scrutiny.

4. Recovery Plan & Trajectory (The "How & When")

- School-readiness work identifies unvaccinated children earlier and expands catch-up opportunities.
- Place-based investment and population health intelligence target areas with lower uptake and greater need.
- Liverpool chosen as a HV pathfinder, however following implementation and discussion with LA colleagues, this is not proving a financially viable or an expectable model of vaccine delivery, with only 84 vacs given to 32 children in 6 months. Further work needs to take place to understand how other alternative options for non-responding families can be explored.
- Coverage data lag means a definitive recovery trajectory cannot be predicted, but evidence-based interventions aim to improve uptake and reduce inequalities.

Ageing Well

a) A&E 4-hour waits
b) A&E 12-hour waits
c) NCTR

Ageing Well

Ageing Well - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assurance	Plan Met	Region Value	National Value	ICB Rank
4-hour A&E waiting time (% waiting less than 4 hours)	Oct-26	71.5%	78.2%		F		71.6%	74.0%	26/36
A&E 12 hour waits from arrival (Type 1 & 2)	Oct-26	17.5%	15.6%	H	?		14.1%	10.7%	34/36
Percentage of beds occupied by patients no longer meeting the criteria to reside	Oct-26	21.3%	15.0%		F		n/a	n/a	n/a
Percentage of people who are discharged from acute hospital to their usual place of residence	Jun-26	84.0%	83.9%	H	F		n/a	n/s	n/a
Reduction in emergency admissions for people aged 65+ (rolling 12 months)	Sep-26	11,273	11,467		?		n/a	n/a	n/a
Reduction in non-elective admissions for patients with frailty (10% reduction against baseline)	Sep-26	5,099	5,428	L	?		0	0	n/a
% CRFD in Mental Health Inpatient beds	Apr-26	5.0%	TBC			TBC	0.0%	0.0%	n/a

A&E 4-hour waits

NHS
Cheshire and Merseyside

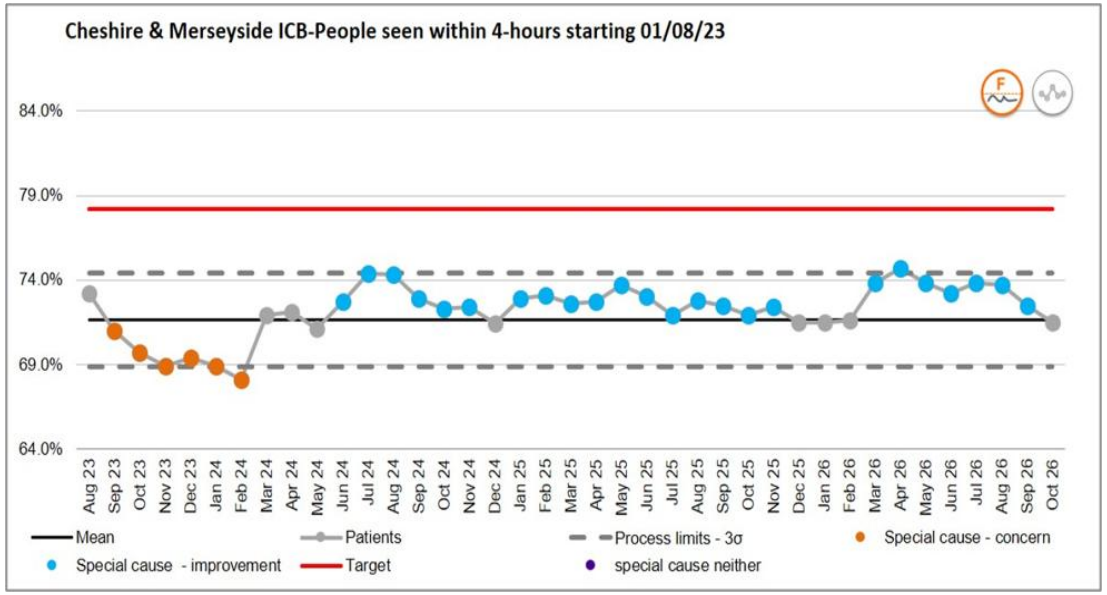
Outcome:

Patients receive timely assessment, treatment and admission/discharge from ED & elimination of long waits to improve safety and experience

Measure of Progress:

An increase in emergency department (ED or A&E) performance towards overall 4-hour target of 85%. We aim for an interim trajectory of 82% by March 2027

Executive Lead: Jude Adams



A&E 4-hour waits

1. **The Performance Gap (The "What")**
- Performance has remained relatively stable throughout 2025/26 and 2026/27; however, October shows an early indication of deterioration to **71.5%**.
- The SPC chart shows sustained special cause improvement when compared to the baseline period in 2023/24, but performance remains significantly below target.

2. **Root Cause Analysis (The "Why")**
- Four-hour performance continues to be constrained by persistent whole-system flow challenges, particularly delays in transferring patients from Emergency Departments into inpatient and community settings.
- Although the system achieved a step change improvement during 2024, subsequent progress has plateaued, suggesting that current improvement initiatives are offsetting demand growth rather than delivering further performance gains.
- Continued pressure across urgent and emergency care pathways, including high bed occupancy, delays in discharge processes and variation in specialty response times, is limiting the system's ability to improve Emergency Department throughput and reduce crowding.

3. **Impact & Risk (The "So What")**
- Poor performance increases the likelihood of prolonged waits in Emergency Departments, impacting patient experience, clinical flow and operational efficiency.
- The October performance raises concern that the system may begin to lose previously achieved gains as seasonal demand pressures increase.
- Without further improvement in patient flow and discharge performance, there remains a risk of worsening crowding, increased ambulance handover delays and reduced resilience across the urgent and emergency care system during winter demand periods.

4. **Recovery Plan & Trajectory (The "How & When")**
- Continue delivery of the C&M urgent and emergency care improvement programme, maintaining focus on Model ED, First 72 Hours and locality-based flow improvement initiatives.
- Intensify provider actions to reduce Emergency Department crowding through improved specialty responsiveness, expedited admission processes and strengthened operational escalation arrangements.
- Maintain a system-wide focus on reducing discharge delays, improving utilisation of community capacity and maximising Same Day Emergency Care pathways to avoid unnecessary admissions.
- Through the Winter Coordination Centre and locality UEC Boards, continue targeted support to organisations demonstrating deteriorating performance, ensuring early intervention where performance trends indicate increased risk during winter 2026/27.

A&E 12-hour waits

NHS
Cheshire and Merseyside

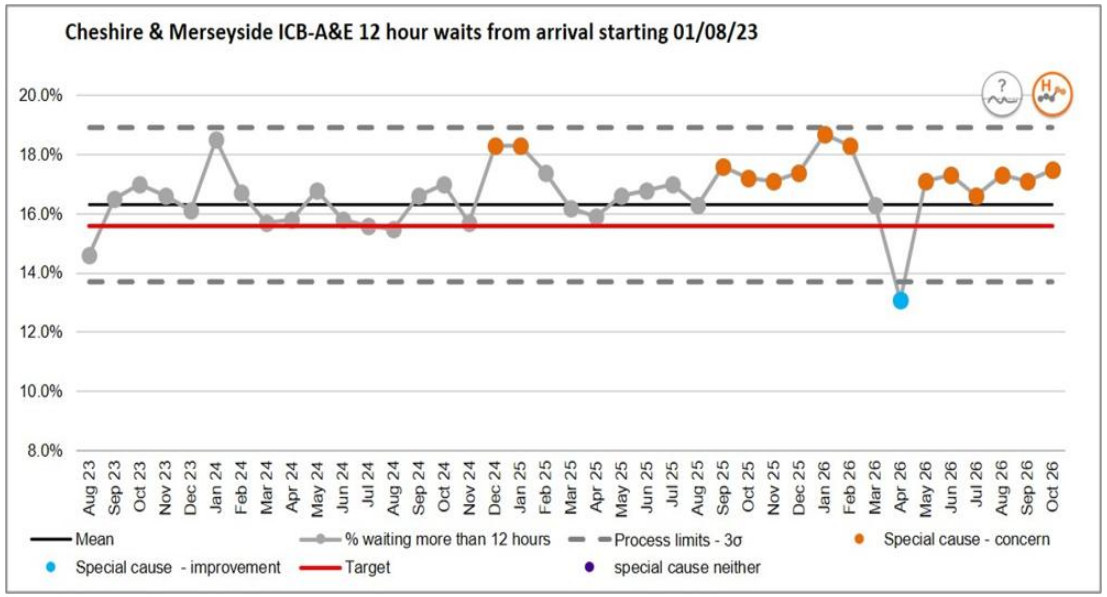
Outcome:

Patients receive timely assessment, treatment and admission/discharge from ED & elimination of long waits to improve safety and experience

Measure of Progress:

A reduction in the number of patients waiting in emergency department (ED or A&E) for over 12 hours.

Executive Lead: Jude Adams



A&E 12-hour waits

1. **The Performance Gap (The "What")**
- The SPC chart demonstrates a sustained pattern of special cause concern, with performance remaining consistently above the process mean. October 2026 shows a further deterioration to 17.5%, reinforcing that reductions in long waits have not been sustained and that performance remains significantly off trajectory.
- Long waits continue to represent one of the most significant challenges within the urgent and emergency care system and remain a key indicator of constraints in patient flow.

2. **Root Cause Analysis (The "Why")**
- 12-hour waits continue to reflect persistent constraints in whole-system flow, delays in moving patients from Emergency Departments into inpatient beds and onward into community settings.
- The chart shows that long waits are embedded within routine system performance rather than being attributable to isolated periods of pressure. Delays in specialty review, bed allocation, inpatient acceptance and discharge processes continue to contribute to prolonged Emergency Department stays.

3. **Impact & Risk (The "So What")**
- Extended waits increase the risk of patient harm, clinical deterioration, corridor care and poor patient experience.
- High levels of 12-hour waits contribute to emergency department crowding, reduced clinical capacity and increased pressure on ambulance handovers and wider urgent care services.
- Current occupancy and discharge challenges increase the likelihood of further deterioration during periods of heightened winter demand.

4. **Recovery Plan & Trajectory (The "How & When")**
- Locality UEC Boards and the Winter Coordination Centre will continue to provide oversight of provider recovery plans and system flow improvement actions, with a range of initiatives planned to reduce bed occupancy and improve flow in the run up to Christmas.
- Providers will maintain systematic review of all 12-hour waits to identify recurring themes, operational barriers and opportunities for rapid intervention.
- Continued focus will be placed on reducing patients no longer meeting criteria to reside, improving discharge performance and lowering acute bed occupancy.
- The immediate ambition is to reduce performance below the **15.6% trajectory**, close the gap to the regional average of **13.4%**, and deliver sustained reductions throughout winter 2026/27.

NCTR

NHS
Cheshire and Merseyside

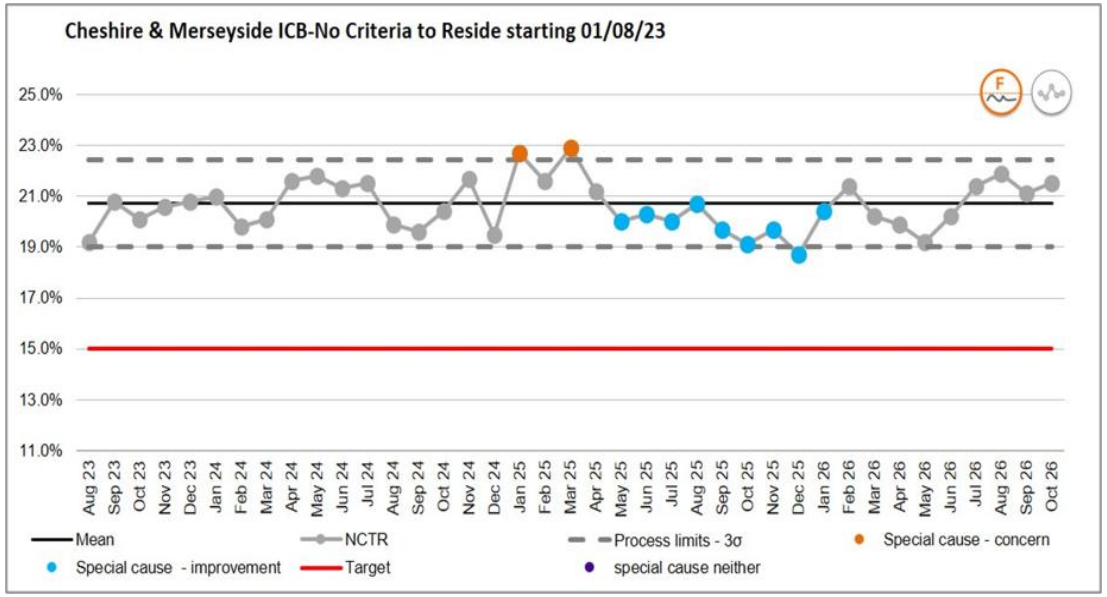
Outcome:

Patients are cared for in the most appropriate setting without delay

Measure of Progress:

A reduction in the % of patients remaining in hospital who do not require to be in hospital.

Executive Lead: Jude Adams



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

1. **The Performance Gap (The "What")**
- In October 2026, 21.3% of acute beds were occupied by patients who no longer met the criteria to reside, significantly above the system ambition of 15.0%.
- Delayed discharge remains one of the most significant constraints on overall patient flow and continues to impact performance across the urgent and emergency care pathway.

2. **Root Cause Analysis (The "Why")**
- Delays in discharge planning, assessment processes and transitions to community services continue to affect performance across acute providers.
- Capacity pressures within domiciliary care, intermediate care, reablement services and complex placement pathways continue to limit timely discharge for medically optimised patients.
- Variation remains across localities in the utilisation of Home First, Pathway 0 and discharge-to-assess models, resulting in inconsistency in discharge performance.
- Rising demand, increasing patient complexity and longer lengths of stay continue to place pressure on discharge pathways and bed availability.

3. **Impact & Risk (The "So What")**
- Prolonged hospital stays increase the risk of deconditioning, hospital-acquired complications and loss of independence for patients who are medically fit for discharge.
- Elevated NCTR levels contribute directly to high bed occupancy, poor emergency department flow, ambulance handover delays and crowding across acute provider sites.
- Continued deterioration in NCTR performance presents a significant risk heading into winter, reducing system resilience and limiting the ability to respond to periods of increased demand.

4. **Recovery Plan & Trajectory (The "How & When")**
- Locality UEC Boards and the Winter Coordination Centre will continue to provide oversight of discharge improvement plans and NCTR reduction trajectories.
- Providers will strengthen daily review processes, executive escalation arrangements and system-wide management of patients no longer meeting criteria to reside.
- System partners will expand utilisation of Home First, Pathway 0, discharge-to-assess and community-based alternatives to support earlier discharge.
- Focus will remain on reducing long lengths of stay, improving access to community capacity and strengthening seven-day discharge arrangements across all localities.
- The immediate ambition is to reverse the recent deterioration and reduce NCTR below 20% during winter 2026/27, before delivering progressive improvement towards the system target of 15%.
- System leaders event taking place on 30th November to support LA and Acute colleagues to unblock barriers and perfect week planned for 7th December.

Dying Well

a) SHMI

Dying Well

Dying Well - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
Reduction in the proportion of our population dying in hospital - All ages	Sep-26	46.7%	47.9%				n/a	42.8%	n/a
Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation	Jun-26	1.019	0.887 to 1.127			n/a	0.000	1.000	n/a

*** Reduction in the proportion of our population dying in hospital:** The ICB Quality team are reviewing the data that sits behind the recent change in this indicator and will provide a more detailed narrative for the next report.

SHMI

NHS Cheshire and Merseyside

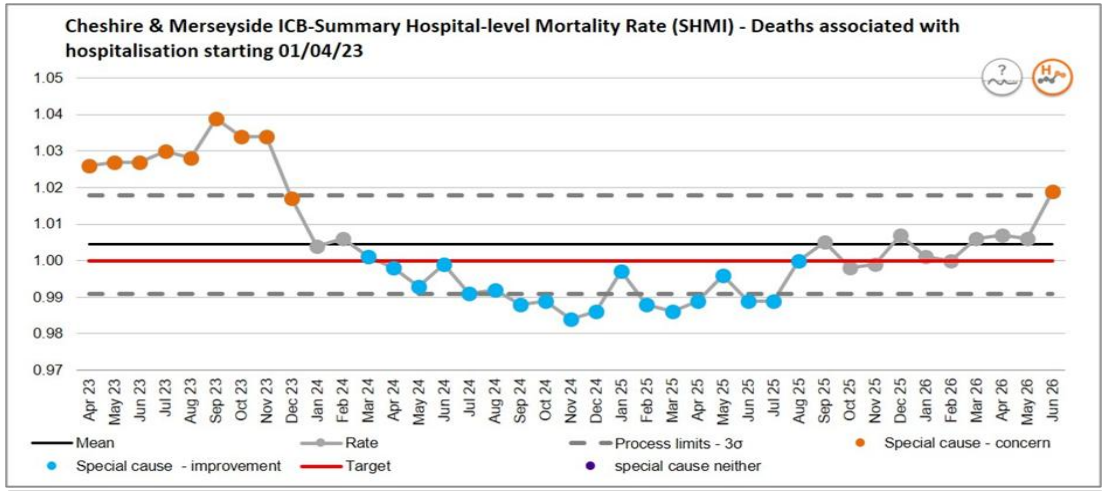
Outcome:

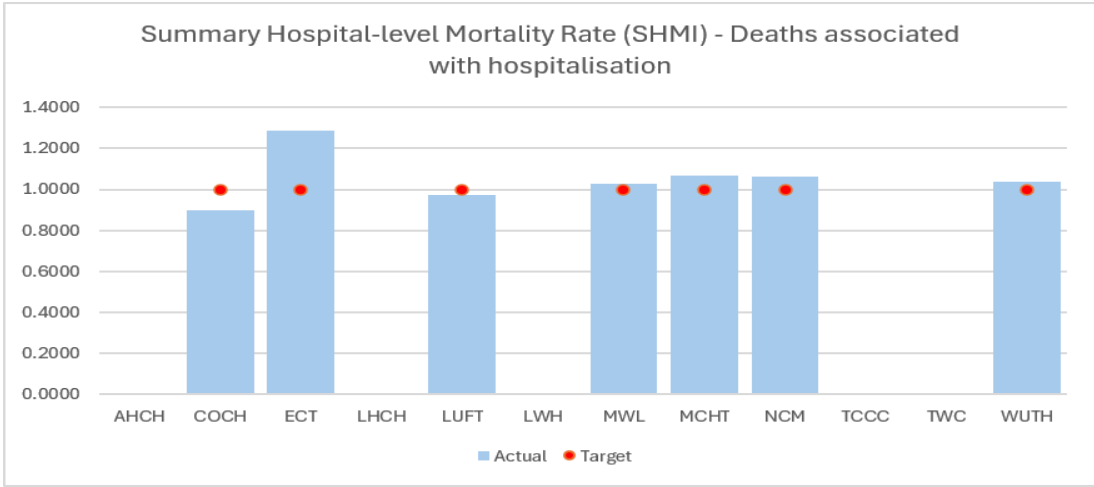
Hospital mortality is in line with or better than expected levels, reflecting safe, high quality care and effective clinical practices

Measure of Progress:

The ration of observed deaths to expected deaths for patients admitted to hospital

Executive Lead: Fiona Lemmens





Summary Hospital-level Mortality Indicator (SHMI)

1. The Performance Gap (The "What")

- One of the main benchmarking indicators for mortality is Summary Hospital Level Mortality Indicator (SHMI)
- Providers are identified as within, higher than or lower than expected ranges
- All providers within the ICB, other than East Cheshire Trust, are within the expected range.
- East Cheshire Hospital Trust is currently higher than expected with a SHMI of 1.2885 against an upper control limit of 1.1813, the Trust has been above the expected range for most of the last 3 years.

2. Root Cause Analysis (The "Why")

- Current SHMI specifically highlights a statistical higher than expected mortality in relation to pneumonia.
- Contextual indicators suggest higher than average mortality for non-elective admissions and deaths within 30 days of discharge, with a lower than average proportion of deaths with palliative coding.

3. Impact & Risk (The "So What")

- There remains a concern about mortality rate at ECT as this higher than expected range is not fully understood. The lack of clarity presents a risk that patients could be subject to avoidable death.

4. Recovery Plan & Trajectory (The "How & When")

- A review of mortality at the provider / following discharge from the provider is taking place and requested reporting via the Clinical Effectiveness Group under Quality and Performance Committee oversight.

Organisational Health (Finance & Workforce)

a) ICB Financial Position
b) Workforce Turnover Rate
c) Sickness Absence Rate
d) Appraisal Compliance Rate
e) Mandatory Training Compliance Rate

Organisational Health

Finance - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assurance	Plan Met	Region Value	National Value	ICB Rank
Variance between ICB Financial Position v Plan £000 (YTD)	Sep-26	£ 3	0.0%			✓	n/a	n/a	n/a
Variance between Capital Spend v Plan £000 (YTD)	Sep-26	£ -	0.0%		P	✓	n/a	n/a	n/a
Variance between CRES v Plan £000 (YTD)	Sep-26	£ 2,209	0.0%	H	?	✓	n/a	n/a	n/a

Workforce - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assurance	Plan Met	Region Value	National Value	ICB Rank
Workforce - total turnover rate	Sep-26	26.6%	10.0%	H	?	✗	0%	0%	n/a
Workforce - sickness absence rate	Sep-26	4.0%	2.5%	L	F	✗	4%	5%	n/a
Appraisal compliance rate	Sep-26	47.5%	95.0%	L	F	✗	0%	0%	n/a
Mandatory training compliance rate	Sep-26	88.8%	95.0%	L	F	✗	0%	0%	n/a

ICB Financial Position

NHS Cheshire and Merseyside

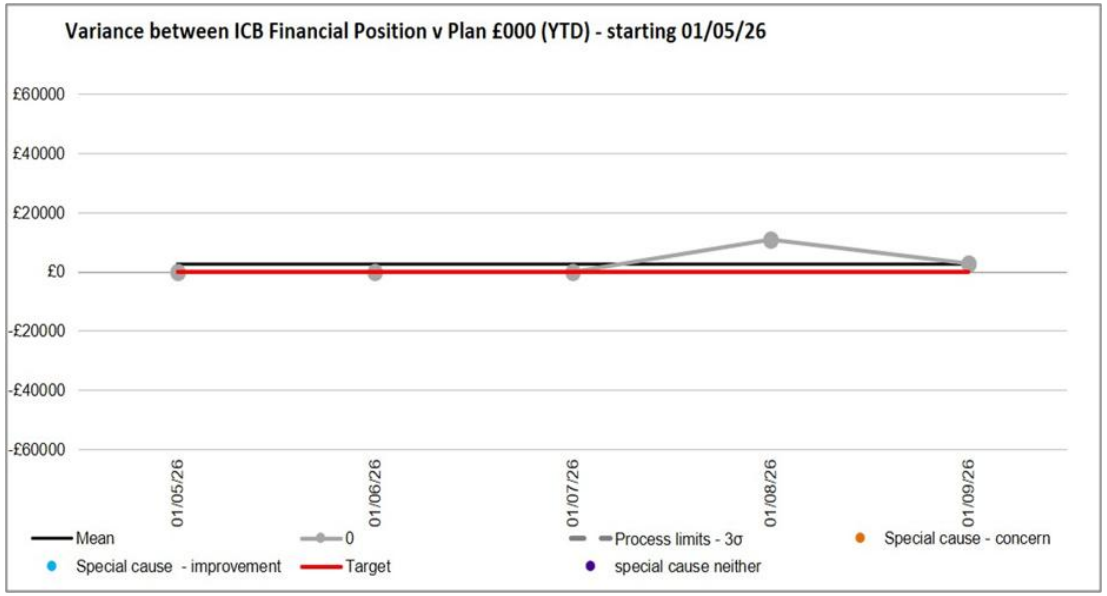
Outcome:

The ICB delivers its planned financial position, demonstrating effective financial management and maintaining system sustainability

Measure of Progress:

This is a financial performance metric that compares the ICB's actual financial position against its planned position.

Executive Lead: Andrea McGee



Variance between ICB Financial Position v Plan

1. The Performance Gap (The "What")

- The ICB reported a year-to-date surplus of £3k for M6 and a Forecast breakeven position.
- The financial plan for 2026/27 is a breakeven position so this is in line with plan at this stage.

2. Root Cause Analysis (The "Why")

Key YTD overspends in following areas:

- Mental Health contracts - £4.8m
- Mental Health Packages of care -£8.6m
- Prescribing -£7.5m
- Other Programmes/Reserves /Balance sheet review/CRES pressure (Grip & Control) partially offset by other underspends) -£11.1m

Offset by the following overspends

- Acute underperformance £4.6m
- Continuing Healthcare £3.9m
- Delegated dental, ophthalmology and pharmacy & medical budgets £22.9m

3. Impact & Risk (The "So What")

- Although a breakeven financial position is reported – in line with plan. The financial risks below are noted:
- Provider activity plans failing to deliver to required RTT improvements.
- Non Elective over-performance is above planned contingency.
- Prescribing/High Cost Drugs – national price changes and increase in weight management drugs
- AACC/MH & Complex Packages of Care cost increase above local planning assumptions
- ADHD continues to grow due to increase in demand including expansion of IS providers in the market CRES schemes do not deliver efficiencies required in year – current risk based on development status £3.2m compared to plan.

4. Recovery Plan & Trajectory (The "How & When")

- Activity query notices submitted to providers
- Investment in “left shift” programmes to manage non-elective activity growth
- Review of Better Care Fund
- Review of controls/zero based budgeting approach
- Escalation of unavoidable prescribing pressures (cat M and NCSO) to NHSE

Workforce Turnover rate

NHS
Cheshire and Merseyside

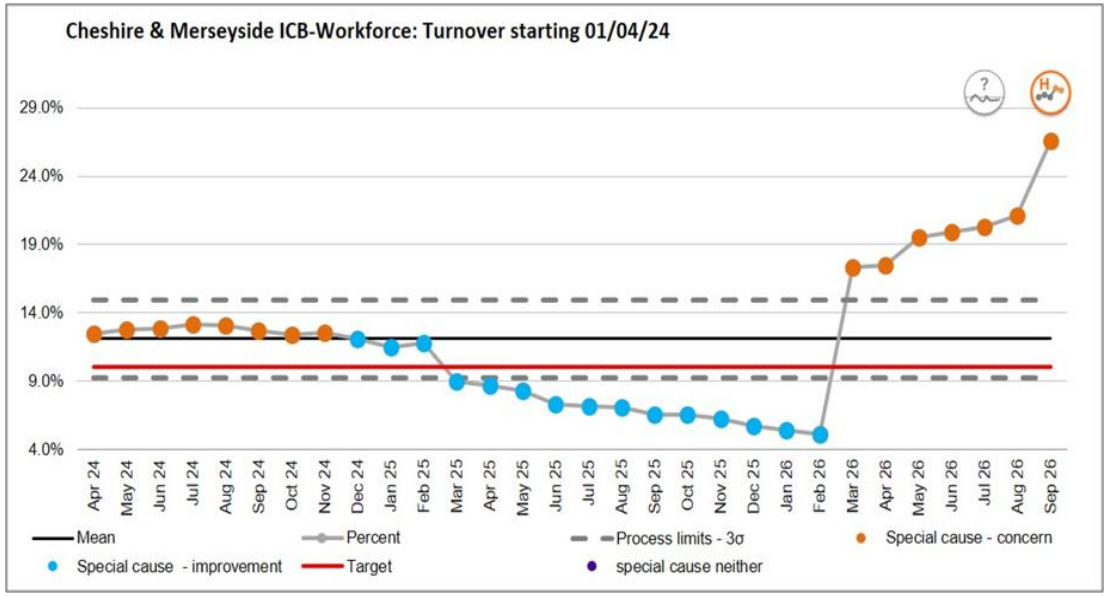
Outcome:

The organisation retains a stable, skilled workforce, reducing vacancies and ensuring high-quality, sustainable service delivery.

Measure of Progress:

The percentage of staff who leave the organisation during a reporting period, usually expressed as an annual turnover rate. The target is <10%.

Executive Lead: Liz Bishop



Workforce Turnover Rate

1. **The Performance Gap (The "What")**
- Workforce turnover has sat below the target of 10% for much of the previous financial year, jumping above target from the start of the current financial year.
- The target has been consistent since the establishment of the ICB and has been achieved the majority of reporting months.

2. **Root Cause Analysis (The "Why")**
- The current spike in turnover remains solely attributable to organisational leavers following the VR1 and VR2 schemes, and the exit of those on 30 September 2026 under the VR3 scheme.
- The turnover rate currently was known and was planned for, and therefore, does not carry the same risk or uncertainty if these leavers were natural and not due to voluntary redundancy.

3. **Impact & Risk (The "So What")**
- The risk is low; when removing leavers under planned schemes, the turnover rate remains a reporting rate that is within target.
- The HR team will continue to monitor the rate monthly and will continue to work with each directorate around retention .

4. **Recovery Plan & Trajectory (The "How & When")**
- The HR team meet monthly with nominated leads in each directorate to discuss workforce metrics including turnover, and this will continue.
- Trends around leavers are reviewed along with leavers checklists and exit interviews to inform areas of improvement.

Sickness Absence Rate

NHS
Cheshire and Merseyside

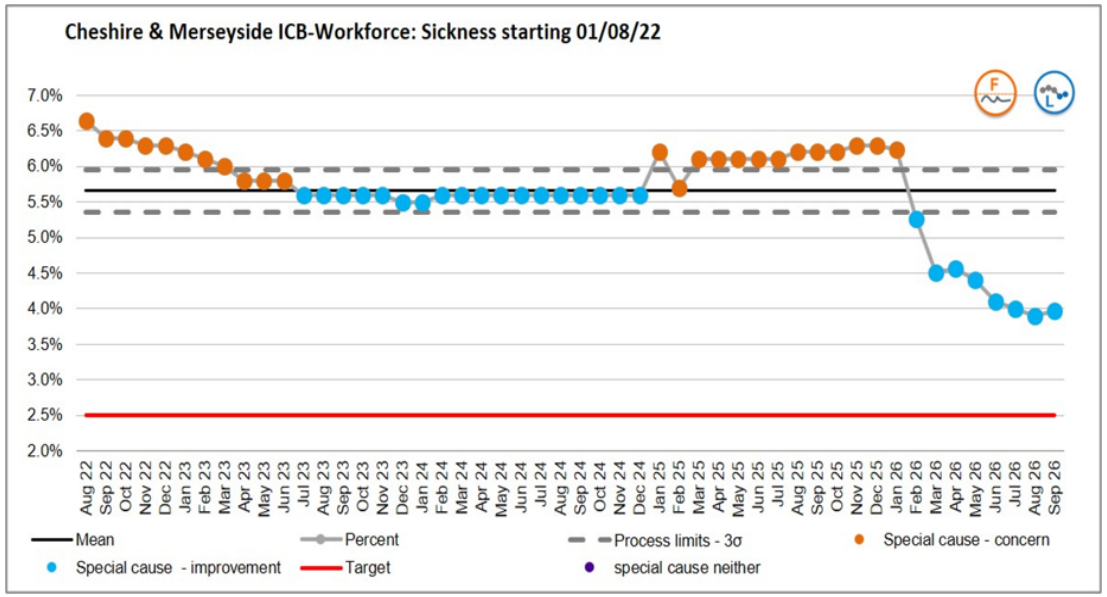
Outcome:

The organisation maintains a healthy and supported workforce, minimising sickness absence and ensuring safe, effective, and sustainable service delivery.

Measure of Progress:

The percentage of total available working time lost due to employee sickness absence during a reporting period. The target is <2.5%.

Executive Lead: Liz Bishop



Sickness Absence Rate

1. **The Performance Gap (The "What")**
- Sickness absence has sat above target for the duration of the ICB establishment (1 July 2022 onward) and has been attributable to a variety of reasons.
- The ICB has a specific attendance management policy concerning attendance and sickness which covers short-term and long-term sickness, and the process to manage such cases.
- A target of 2.5%, when the organisation headcount fluctuated around 1100-1200 staff for most of its establishment, would equate to 27.5 to 30 or fewer individuals being absent at any one time.

2. **Root Cause Analysis (The "Why")**
- The main two attributable reasons for sickness remain related to 'stress/anxiety/depression' (work and/or non work related) and musculoskeletal problems. These are not dissimilar to other NHS organisations.
- From March 2025, sickness increased and we believe this to be attributable to uncertainty regarding ICB running costs and post reductions, coupled with absences that naturally occur regardless of organisational state.

3. **Impact & Risk (The "So What")**
- A change of approach in policy in early 2026 enabled a differing approach to managing sickness cases. This enabled quicker progress through the differing absence management stages, whilst maintaining an ability to manage cases compassionately and with care. Since the update, the absence rate has started to reduce (January 2026 onward) and remains at a lower rate month-on-month, being at its lowest since the ICB establishment in August 2026.
- Whilst this policy change has had a visible impact, we also believe the commencement of the organisational wide management of change has lowered the absence rate due to individuals wishing to remain in work to keep across progress of this change. We are however conscious of increasing absence now MoC has mainly concluded, and particularly conscious of absences resulting from the outcome/s of this process.

4. **Recovery Plan & Trajectory (The "How & When")**
- Following conclusion of the management of change (September to October 2026), we continue to expect sickness to rise and for some cases, be mainly or wholly attributable to workplace uncertainty, or outcomes.
- We are focussing further work on the management of short-term cases too, in addition to those considered long-term (28 days or more). Interventions made early and a change of policy drove improvements for long-term absences, and we're hopeful the same will apply for short-term.

Appraisal Compliance Rate

NHS
Cheshire and Merseyside

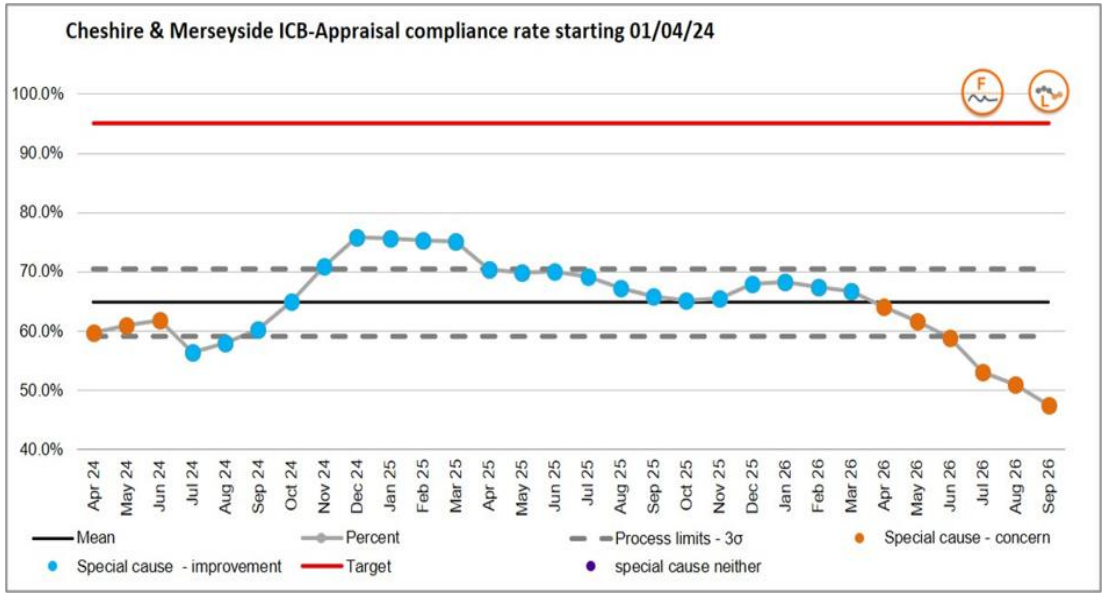
Outcome:

Staff receive a timely annual appraisal that supports personal development, improves performance, and contributes to high-quality patient care.

Measure of Progress:

An increase in the percentage of eligible staff who have received a completed appraisal within the previous 12 months. The target is 95%.

Executive Lead: Liz Bishop



Appraisal Compliance Rate

1. The Performance Gap (The "What")

- Appraisal compliance has sat below the ICB target of 95% since the ICB establishment in July 2022.
- Appraisals should be held yearly, between employee and line manager, and recorded on the personal file and ESR.
- We are aware that the true compliance rate is slightly higher (2-3%) than the reported amount due to some managers not inputting the appraisal details into ESR.

2. Root Cause Analysis (The "Why")

- The current reduction in compliance is mainly attributable to the ongoing organisational change and uncertainty of roles.
- We are aware many managers holding conversations to 'roll over' the previous appraisals, with the intention of holding a new appraisal once certainty is felt following conclusion of organisational change.
- Engagement between line manager and employee is impacted by uncertainty regarding roles and structures, and therefore, the value of an appraisal at this stage does not appear as much.

3. Impact & Risk (The "So What")

- Further work following the end of organisational change will focus on upskilling line managers to embed skills to be able to hold appraisals that add value, aligning to succession planning, and develop the employee.
- Directorate meetings between HR and the exec lead are also focussing on appraisal compliance with a commitment of senior leaders to cascade compliance figures to their team to help drive compliance. Most staff are now confirmed in posts and roles, which will enable the completion of appraisals to set objectives against newly confirmed roles.

4. Recovery Plan & Trajectory (The "How & When")

- The introduction of a refreshed appraisal process remains on track for commencement in early 2027 following trial earlier this year by the People team. This builds on employee feedback via the staff survey, staff engagement forum, and general appraisal feedback.
- ESR reporting guidance has been refreshed and is due to be shared to ensure that appraisals are input into ESR once held to improve the compliance rate.

Mandatory Training Compliance Rate

NHS Cheshire and Merseyside

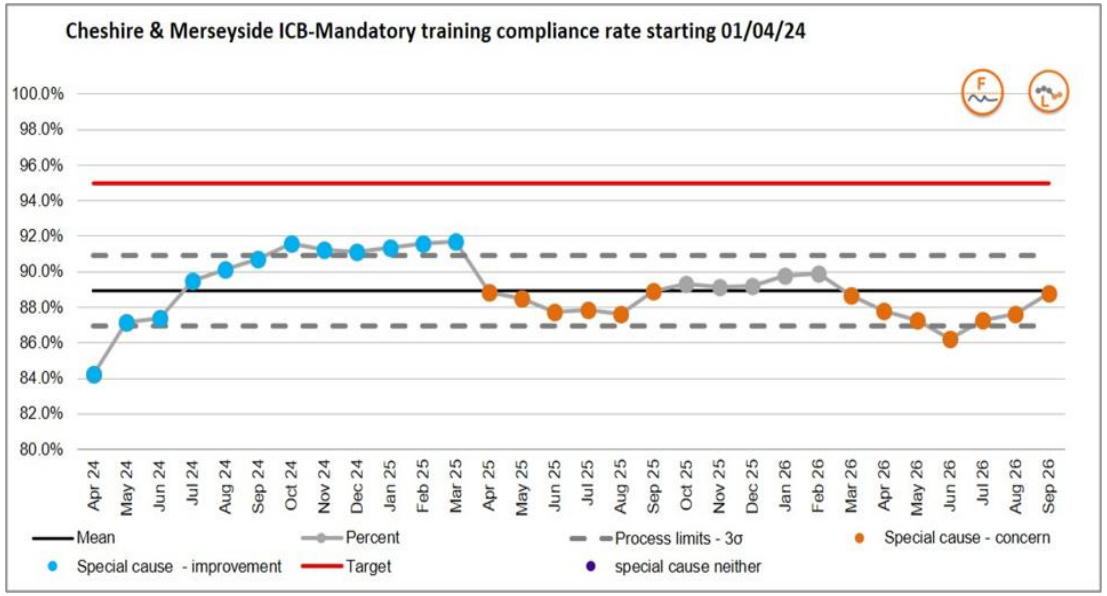
Outcome:

Staff are appropriately trained and up to date with mandatory training requirements, supporting safe, effective, and compliant healthcare delivery.

Measure of Progress:

An increase in the percentage of eligible staff who have completed all required mandatory training modules. The target is 95%.

Executive Lead: Liz Bishop



Mandatory Training Compliance Rate

1. **The Performance Gap (The "What")**
- The ICB target compliance rate for statutory and mandatory training is 95% with most employees being required to complete between 16 and 21 courses at differing frequencies (yearly; every two years; every three years).
- Staff in clinical and/or patient/public facing roles are required to complete up to 21 courses due to their work focussing on clinical and/or public engagement.
- Apart from unique rare role-specific courses, all training is completed via the ESR self service portal, and line managers can view the compliance rate/s of their direct report/s.

2. **Root Cause Analysis (The "Why")**
- The current compliance has remained stable between 87% & 90% over the past 18 months but has only been above 90% once in that time.
- For most of the time, when viewed alongside sickness data, as sickness levels increased, mandatory training levels started to reduce. This direct link is attributable to compliance expiring of staff absent due to sickness, and operational pressures of those within the workplace driven by lower staffing levels resulting in completion of training becoming a lesser priority.
- The ICB do not currently remove absent staff from mandatory training compliance reports.

3. **Impact & Risk (The "So What")**
- The visible data demonstrates that as sickness has reduced, compliance has started to increase for mandatory training as can be seen from July 2026 onward for both sickness and mandatory training compliance.

4. **Recovery Plan & Trajectory (The "How & When")**
- Compliance reminder emails will continue within teams highlighting where a staff member has dropped below 95% compliance with their mandatory training. These are currently led by service leads, but further work will follow to embed this within line management responsibilities.
- Reminders are to be issued highlighting that lack of compliance can impact pay progression and the expected standards of staff within the ICB.

Integrated Performance Report

Appendix

a) 13-month trend
b) Provider Capability & Segmentation Ratings
c) Guidance
d) SPC Guidance

ICB Aggregate Position - 13 month trend

NHS Cheshire and Merseyside

Domain	Metric	Latest Month	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Target	Regional	National	Ranking
Starting well	Still birth per 1,000 (rolling 12 months) (MSDS)	Year to May 26	3.1	3.1	3.1	3.1	2.8	2.8	2.8	2.8						2.6	n/a	3.8	n/a
Starting well	Pre Term Births	May-26	5.2%	5.4%	5.9%	6.9%	5.1%	5.1%	5.0%	6.6%						6.0%	n/a	n/a	n/a
Starting well	Breast Milk at First Feed %	May-26	67.5%	67.4%	65.8%	65.8%	66.2%	67.9%	68.2%	66.8%						74.0%	n/a	n/a	n/a
Growing Well	Number of 52+ week RTT waits, of which children under 18 years.	Sep-26	992	947	847	731	767	501	478	451	454	445	377	368		0	n/a	n/a	n/a
Growing Well	Number of unique patients seen by an NHS Dentist – Children (12 month)	Sep-26	338,502	338,564	340,663	340,812	341,643	343,051	343,629	344,053	344,993	345,714	346,201	346,047		338,408	1,060,028	7,414,932	n/a
Living Well	The % of people waiting less than 18 weeks on the waiting list (RTT)	Sep-26	59.4%	59.1%	58.7%	58.8%	60.7%	64.5%	64.7%	65.2%	65.6%	65.7%	65.9%	66.5%		66.2%	65.2%	65.9%	16/36
Living Well	The % of people waiting more than 52 weeks on the waiting list (RTT)	Sep-26	3.3%	2.9%	2.4%	2.2%	1.9%	1.1%	1.1%	1.2%	1.2%	1.3%	1.3%	1.3%		0.9%	1.4%	1.6%	18/36
Living Well	Patients waiting more than 6 weeks for a diagnostic test	Sep-26	9.5%	9.2%	10.2%	10.7%	7.1%	9.8%	13.0%	12.4%	12.2%	13.2%	13.8%	12.1%		7.7%	14.2%	22.6%	4/36
Living Well	Number of unique patients seen by an NHS Dentist – Adults (24 month)	Sep-26	947,758	947,371	950,458	951,752	952,810	955,218	956,282	956,039	957,646	958,662	958,503	959,063		966,320	2,699,201	18,525,370	n/a
Living Well	% of urgent GP appointments seen within 24 hours	Sep-26	74.3%	74.3%	76.6%	75.6%	74.7%	75.3%	77.6%	79.0%	79.7%	79.8%	79.8%	80.3%		82.0%	79.0%	77.1%	n/a
Living Well	Percentage of ICB inappropriate out of area placement bed days in Adult acute beds	Aug-26	3.0%	2.0%	3.0%	3.0%	2.0%	2.0%	1.9%	2.0%	2.0%	1.7%	1.6%			TBC	1.6%	2.0%	15/36
ving Healthy Liv	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Sep-26	72.3%	74.2%	74.6%	71.1%	73.5%	79.9%	76.9%	74.4%	76.7%	76.2%	77.0%	74.2%		77.3%	n/a	70.7%	7/36
ving Healthy Liv	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Sep-26	73.6%	74.8%	75.3%	71.6%	80.7%	81.2%	77.2%	78.9%	76.8%	77.2%	74.1%	74.5%		76.8%	n/a	76.2%	24/36
ving Healthy Liv	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems. (Aged 15+)	Oct-26	13.8%	16.4%	16.3%	16.3%	16.2%	16.1%	16.1%	16.0%	15.9%	15.9%	15.9%	15.7%	15.7%	12.0%		12.7%	n/a
ving Healthy Liv	Cervical Screening Rate	Oct-26	68.6%	68.5%	68.9%	69.0%	69.1%	69.3%	69.3%	69.0%	69.0%	68.9%	68.7%	68.3%	68.2%	80.0%			n/a
ving Healthy Liv	Bowel Screening Rate	Oct-26	69.9%	69.9%	70.2%	70.2%	70.3%	70.3%	70.3%	70.3%	70.4%	70.5%	70.6%	70.8%	70.9%	62.0%			n/a
ving Healthy Liv	Breast Screening Rate	Oct-26	71.7%	71.7%	72.1%	72.1%	71.9%	71.5%	71.5%	71.3%	71.0%	70.8%	70.4%	69.8%	68.5%	70.0%			n/a
ving Healthy Liv	MMRV Uptake (2 doses by fifth birthday) (see Note)	Q1 26/27	85.0%			83.1%			83.70%							95%	84.1%	82.3%	27/37

ICB Aggregate Position - 13 month trend

NHS Cheshire and Merseyside

Domain	Metric	Latest Month	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Target	Regional	National	Ranking
Ageing Well	4-hour A&E waiting time (% waiting less than 4 hours)	Oct-26	71.9%	72.4%	71.5%	71.5%	71.6%	73.8%	74.7%	73.8%	73.2%	73.8%	73.7%	72.5%	71.5%	78.2%	71.6%	74.0%	26/36
Ageing Well	A&E 12 hour waits from arrival (Type 1 & 2)	Oct-26	17.2%	17.1%	17.4%	18.7%	18.3%	16.3%	13.1%	17.1%	17.3%	16.6%	17.3%	17.1%	17.5%	15.6%	14.1%	10.7%	34/36
Ageing Well	Percentage of beds occupied by patients no longer meeting the criteria to reside	Oct-26	19.1%	19.7%	18.7%	20.4%	21.4%	20.2%	19.9%	19.2%	20.2%	21.4%	21.9%	21.1%	21.3%	15%	n/a	n/a	n/a
Ageing Well	Percentage of people who are discharged from acute hospital to their usual place of residence	Jun-26	83.6%	82.0%	82.2%	80.9%	82.1%	83.2%	83.3%	83.4%	84.0%					83.9%	n/a	n/s	n/a
Ageing Well	Reduction in emergency admissions for people aged 65+ (rolling 12 months)	Sep-26	11,937	10,987	11,707	11,783	10,385	11,893	11,578	11,589	11,628	12,249	11,394	11,273		11,467	n/a	n/a	n/a
Ageing Well	Reduction in non-elective admissions for patients with frailty (10% reduction against baseline)	Sep-26	5,696	5,149	5,270	5,527	5,167	5,909	5,857	5,676	5,632	5,620	5,457	5,099		5,428			n/a
Ageing Well	% CRFD in Mental Health Inpatient beds	Apr-26	15.0%	18.0%	16.0%	20.0%	20.0%	21.0%	5.0%							TBC			n/a
Dying Well	Reduction in the proportion of our population dying in hospital - All ages	Sep-26	46.1%	48.3%	46.9%	49.0%	46.8%	47.0%	49.3%	46.8%	47.3%	48.1%	45.0%	46.7%		47.9%	n/a	42.80%	n/a
Dying Well	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation	Jun-26	0.998	0.999	1.007	1.001	1.000	1.006	1.007	1.006	1.019					0.887 to 1.127		1.000	n/a
ganisational Hea	Variance between ICB Financial Position v Plan £000 (YTD)	Sep-26	(979)	(962)	(7,129)	(18,231)	(29,749)	(50,334)	n/a	£ -	£ -	£ -	£ 11	£ 3		£0			n/a
ganisational Hea	Variance between Capital Spend v Plan £000 (YTD)	Sep-26	£ 700	£ 700	£ 700	£ 700	£ -	£ 24,012	n/a	£ -	£ -	£ -	£ -	£ -		£0			n/a
ganisational Hea	Variance between CRES v Plan £000 (YTD)	Sep-26	(10,674)	(9,636)	(5,583)	(4,236)	(5,511)	(9,327)	n/a	(693)	(575)	£ 1,464	£ 207	£ 2,209		£0			n/a
ganisational Hea	Workforce - total turnover rate	Sep-26	6.6%	6.3%	5.7%	5.4%	5.1%	17.4%	17.5%	19.5%	19.9%	20.3%	21.1%	26.6%		10%			n/a
ganisational Hea	Workforce - sickness absence rate	Sep-26	6.2%	6.3%	6.3%	6.2%	5.3%	4.5%	4.6%	4.4%	4.1%	4.0%	3.9%	4.0%		2.5%	4.4%	5.1%	n/a
ganisational Hea	Appraisal compliance rate	Sep-26	65.1%	65.5%	68.0%	68.4%	67.4%	66.7%	64.2%	61.6%	58.8%	53.0%	51.0%	47.5%		95%			n/a
ganisational Hea	Mandatory training compliance rate	Sep-26	89.3%	89.1%	89.2%	89.8%	89.9%	88.7%	87.8%	87.3%	86.2%	87.3%	87.6%	88.8%		95%			n/a

Oversight Framework - Capability, Segmentations and Ratings

NHS Cheshire and Merseyside

C&M Acute and Specialist Trusts

	Latest Capability Rating	2025/26 Published Ratings				2026/27	2025/26 Published League Table Position				2026/27
Trust		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1***
Liverpool Heart and Chest Hospital NHS Foundation Trust	Green	1	1	1	1	1	4/134	3/134	5/134	4/134	**1/134**
The Clatterbridge Cancer Centre NHS Foundation Trust	Green	1	1	1	1	1	8/134	9/134	7/134	10/134	**4/134**
Alder Hey Children's Hospital NHS Foundation Trust	Green	1	1	1	1	1	16/134	10/134	14/134	15/134	**11/134**
The Walton Centre NHS Foundation Trust	Green	1	1	1	1	**2**	7/134	5/134	13/134	14/134	**20/134**
Liverpool Women's NHS Foundation Trust	Amber/Red	3	4	3	3	3	68/134	109/134	93/134	72/134	**50/134**
Mersey and West Lancashire Teaching Hospitals Trust	Amber/Green	3	3	3	3	3	56/134	51/134	83/134	56/134	**51/134**
Mid Cheshire Hospitals NHS Foundation Trust	Amber/Red	3	4	4	3	3	96/134	115/134	118/134	94/134	**65/134**
Countess of Chester NHS Foundation Trust	Red	4	4	4	3	3	133/134	132/134	122/134	98/134	**95/134**
North Cheshire & Mersey NHS Foundation Trust	Amber/Red	4 (as Warrington & Halton)				**3**	118/134	125/134	106/134	102/134	**97/134**
Wirral University Teaching Hospitals NHS Foundation Trust	Red	4	4	4	4	**3**	107/134	110/134	124/134	123/134	**99/134**
East Cheshire NHS Trust	Amber/Green	3	4	4	4	4	99/134	119/134	122/134	126/134	**120/134**
Liverpool University Hospitals NHS Foundation Trust	Amber/Red	4	4	4	4	4	116/134	111/134	113/134	109/134	**126/134**

Notes:
i) Green text indicates an improvement in rating/ranking between Q4 of 2025/26 and Q1 of 2026/27, Red text indicates a deterioration
ii) North Cheshire & Mersey were previously rated as Segment 4 for each quarter of 2025/26, as Warrington & Halton NHS Foundation Trust
iii) *Trusts are ordered by their 2026/27 Q1 ranking
iv) The 2026/27 Oversight Framework uses a refreshed set of metrics and methodology. Further information can be found at https://www.england.nhs.uk/nhs-oversight-framework/

Oversight Framework - Capability, Segmentations and Ratings

NHS Cheshire and Merseyside

C&M Non Acute Trusts

	Latest Capability Rating	2025/26 Published Ratings				2026/27	2025/26 Published League Table Position				2026/27
Trust		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1***
Mersey Care NHS Foundation Trust	Amber/Red	2	2	2	2	2	25/61	22/61	23/61	24/61	**14/58**
Wirral Community Health and Care NHS Foundation Trust	Green	1	1	1	1	**2**	12/61	9/61	9/61	10/61	**16/58**
Cheshire and Wirral Partnership NHS Foundation Trust	Amber/Green	4	3	3	3	**2**	49/61	44/61	47/61	45/61	**29/58**
Bridgewater Community Healthcare NHS Foundation Trust	Amber/Green	3	3	3	4	N/A	39/61	30/61	37/61	61/61	N/A

Ambulance Trust - for info only

	2025/26 Published Ratings				2026/27	2025/26 Published League Table Position				2026/27
Trust	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
North West Ambulance Service NHS Trust		1	1	1	**2**		1/10	1/10	3/10	tbc

Notes:

i) Green text indicates an improvement in rating/ranking between Q4 of 2025/26 and Q1 of 2026/27, Red text indicates a deterioration

ii) Bridgewater were previously rated during 2025/26, however for 2026/27, please refer to North Cheshire & Mersey NHS Foundation Trust

iii) *Trusts are ordered by their 2026/27 Q1 ranking

iv) The 2026/27 Oversight Framework uses a refreshed set of metrics and methodology. Further information can be found at https://www.england.nhs.uk/nhs-oversight-framework/

Integrated Quality & Performance Report – Guidance:

NHS Cheshire and Merseyside

Provider Acronyms:

CHESHIRE & MERSEYSIDE TRUSTS

AHCH	ALDER HEY CHILDREN'S HOSPITAL NHS FT
COCH	COUNTESS OF CHESTER HOSPITAL NHS FT
CWP	CHESHIRE AND WIRRAL PARTNERSHIP NHS FT
ECT	EAST CHESHIRE NHS TRUST
LHCH	LIVERPOOL HEART AND CHEST HOSPITAL NHS FT
LUFT	LIVERPOOL UNIVERSITY HOSPITALS NHS FT
LWH	LIVERPOOL WOMEN'S NHS FT
MWL	MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST
MCFT	MERSEY CARE NHS FT
MCHT	MID CHESHIRE HOSPITALS NHS FT
NCM	NORTH CHESHIRE AND MERSEY NHS FT
TCCC	THE CLATTERBRIDGE CANCER CENTRE NHS FT
TWC	THE WALTON CENTRE NHS FT
WCHC	WIRRAL COMMUNITY HEALTH AND CARE NHS FT
WUTH	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT

KEY SYSTEM PARTNERS

NWAS	NORTH WEST AMBULANCE SERVICE NHS TRUST
CMCA	CHESHIRE AND MERSEYSIDE CANCER ALLIANCE
CMPC	CHESHIRE AND MERSEYSIDE PROVIDER COLLABORATIVE

OTHER

OOA	OUT OF AREA AND OTHER PROVIDERS

Key:

Data formatting

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

C&M National Ranking against the 42 ICBs

≤11th	C&M in top quartile nationally
12th to 31st	C&M in interquartile range nationally
≥32nd	C&M in bottom quartile nationally
-	Ranking not appropriate/applied nationally

C&M National Ranking against the 22 Cancer Alliances

≤5th	C&M in top quartile nationally
6th to 17th	C&M in interquartile range nationally
≥18th	C&M in bottom quartile nationally
-	Ranking not appropriate/applied nationally

Notes on interpreting the data

Latest Period: The most recently published, validated data has been used in the report, unless more recent provisional data is available that has historically been reliable. In addition, some metrics are only published quarterly, half yearly or annually - this is indicated in the performance tables.

Historic Data: To support identification of trends, up to 13 months of data is shown in the tables, the number of months visible varies by metric due to differing publication timescales.

Local Trajectory: The C&M operational plan has been formally agreed as the ICBs local performance trajectory and may differ to the national target

RAG rating: Where local trajectories have been formalised the RAG rating shown represents performance against the agreed local trajectories, rather than national standards. It should also be noted that national and local performance standards do change over time, this can mean different months with the same level of performance may be RAG rated differently.

National Ranking: Ranking is only available for data published and ranked nationally, therefore some metrics do not have a ranking, including those where local data has been used.

Target: Locally agreed targets are in **Bold Turquoise**. National Targets are in **Bold Navy**.

Integrated Quality & Performance Report – Interpreting SPC Charts:

NHS Cheshire and Merseyside

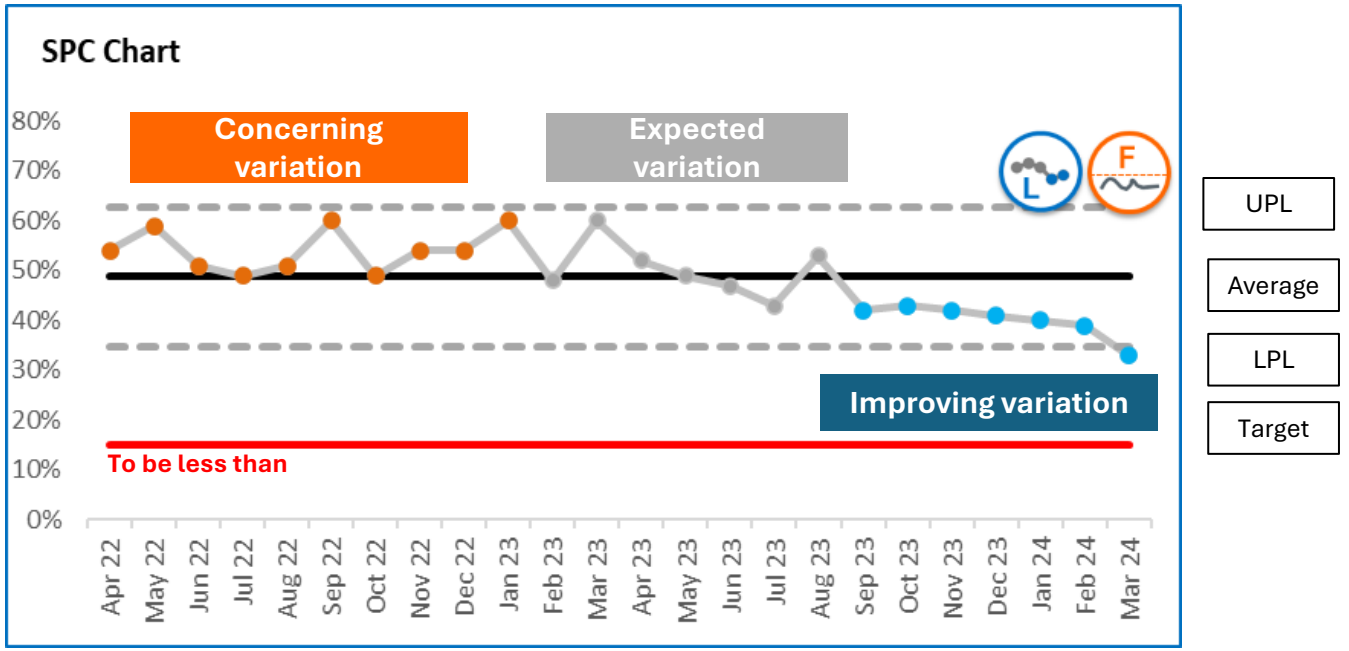
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated, and improvement actions implemented

Blue – there is a pattern of improvement which should be learnt from

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable



The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the **red** line) can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

Integrated Quality & Performance Report – Interpreting summary icons:

NHS Cheshire and Merseyside

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

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

Meeting of the Quality & Performance Committee of NHS Cheshire and Merseyside

Date: September/October 2026

Highlight report of the Chair of the Quality & Performance Committee

Agenda Item No: **ICB/11/26/26/19**

Report completed by: **Tony Foy**

Committee Chair: **Tony Foy**

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/

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

Safeguarding

- The safeguarding exception report provided an overview of statutory safeguarding responsibilities across the system and highlighted areas requiring enhanced oversight. Continuing challenges associated with initial health assessments for children entering care were reported. Performance remained significantly below expected levels across most places, the exception being St Helens, with significant challenges in performance of in-area initial assessments apparent in Warrington, Liverpool, Wirral, Knowsley and Sefton. Reviews of assessments are performing better but initial assessments are continuing to fall below 60%.
- Members noted that this issue had been recognised as a system-wide risk by the Corporate Parenting Board, which had established a task and finish group to examine commissioning models and multi-agency contributions. The committee accepted that safeguarding is complex pathway issue involving health, local authorities and providers, and that improvements would require coordinated action rather than isolated interventions. The Committee further agreed that future reporting should focus more explicitly on outcomes, inequalities and the measurable impact of pathway changes, rather than solely on activity levels.
- The Committee was informed of concerns regarding safeguarding leadership at the Trust which the new interim Chief Executive and interim Chief Nursing Officer had acknowledged and were committed to accelerating improvements. The Trust had been advised to increase the safeguarding risk rating on its internal register.

AACC

- The 28-day KPI (eligibility decision) for Q1 26/27 was only achieved by St Helens and Knowsley. There was an overall deterioration across the ICB from Q4 63.9% to Q1 54.1%. Cheshire, Halton, Knowsley, Southport & Formby, Warrington and Wirral all saw a deterioration in the 28-day KPI in Q1. This is mainly associated with the level of vacancies across the service because of a previous recruitment freeze, sickness/absence levels and social worker availability. Internal workforce pressures are now being addressed through the workforce recruitment and development plans and social worker availability is improving.

ADVISE – Key Points for Board Awareness and Action

Committee Workplan

- The August reset meeting highlighted the need for the Committee to shift from a predominantly organisation-specific assurance model to a more strategic, pathway-based approach aligned to the ICB's population health improvement priorities. The intention is for future agendas to focus on thematic areas that reflect system priorities rather than isolated provider issues, the first being all age Mental Health in November.
- The Committee also reflected on the broader challenge of ensuring alignment between committee discussions, system risks and the Board Assurance Framework. It was noted that the organisation had inherited legacy risks from former CCGs and that

a refreshed approach was required to ensure the BAF accurately reflects the new strategic commissioning model. Members agreed that the Committee's thematic pathway focus would support this shift, while still maintaining appropriate oversight of provider quality and safety. An updated model will be discussed at the November meeting.

- There was agreement that patient experience reporting should be integrated with complaints rather than treated separately, and that future iterations of the workplan should reflect this.

Infection Prevention & Control/ Anti-microbial resistance

- The Committee received the IPC/AMR assurance update as part of its routine oversight of infection prevention, control and antimicrobial resistance across the system. The committee noted that there is a great deal of work to be done to improve Healthcare Associated Infections rates to achieve the tolerances set nationally. It was acknowledged that IPC performance had been affected by wider operational pressures, including workforce constraints and variation in provider capability, and that this continued to influence the consistency of delivery across the system
- Further work is required to seek assurance of both individual organisational improvement work and compliance with system toolkits, specifically Clostridioides Difficile Infection (CDI). Q1 performance is over trajectory for all infections including 35% over for CDI. The ongoing actions include individual improvement plans at each Trust, the use of a CDI toolkit across the provider collaborative and antimicrobial stewardship programmes. The CDI toolkit launched in Q2 2025/26, has seen a 9% reduction in cases across NHS Trusts to Q1 2026/27. There has been variation in the impact across providers with significant reductions at Wirral University Hospital, Clatterbridge and Alder Hey (41%, 57% and 75% reductions), but there have been minimal changes at some and actual increases at Countess of Chester, Liverpool University Hospital, Walton Centre and Liverpool Heart and Chest Hospital.
- Antimicrobial stewardship has continued to be a key priority in addressing rates of Healthcare Associated Infections. This has focused on General Medical Practice prescribing with objectives which include:
  - reducing total antibiotic items,
  - reducing the proportion of Co-amoxiclav, Cephalosporins and Quinolones within the antibiotic items prescribed,
  - reducing the length of prescriptions (moving to 5-day courses for Amoxicillin and doxycycline),
  - reducing the rate of primary care prescribing of antibiotics for children aged 0-9 years.

SEND

- Members noted that recent SEND inspection outcomes across the region had been challenging, reflecting a national trend in which only around one-fifth of areas achieve positive results under the current inspection framework with multiple areas requiring significant improvement.
- Neurodiversity waiting times remain a significant and persistent issue and long waits for assessment and support continue to affect children and families across the region. A major programme of work is underway within the mental health and neurodiversity team, supported by Left Shift funding, to address these delays. It was confirmed that reducing waits below 52 weeks across Cheshire & Merseyside by year-end is unlikely despite ongoing investment.
- The report also highlighted new national requirements for strategic speech and language therapy leadership posts. There was debate about whether these roles should sit within the ICB or within provider organisations, the national guidance is not entirely clear, and the region will need to determine the most effective and sustainable model.

Performance

September the Integrated Performance report identified the following areas of concern:

- UEC performance was identified as the most significant area. Members highlighted ongoing pressures relating to 12-hour waits, ambulance handover delays and challenges in patient flow. It was noted that UEC issues are system-wide and require coordinated action across providers, community services and local authorities.
- The Committee acknowledged continued strong performance in diagnostics and cancer pathways

October

- Urgent and Emergency Care remains the most significant operational challenge, with A&E 12-hour waits worsening, delayed discharge levels remaining high, and patients no longer meeting criteria to reside continuing to constrain flow and capacity.
- Diagnostic recovery remains off trajectory, with ongoing endoscopy capacity constraints, and deteriorating performance from independent sector providers offsetting NHS improvements.
- Long waits for children and young people remain a significant concern, particularly community paediatric and neurodevelopmental pathways where demand continues to outstrip available capacity.
- Talking Therapies recovery outcomes continue to deteriorate, remaining below target and demonstrating significant provider variation

ASSURE – Positives, Progress and Areas of Strength

Maternity

- LMNS has undertaken a detailed review of provider capability, including clinical leadership, governance structures, workforce resilience and the maturity of safety systems. This review identified areas where capability was strong and others where gaps remained, particularly in relation to data quality, escalation processes and the consistency of clinical oversight.
- Members discussed the importance of ensuring that risks identified through LMNS assurance were reflected appropriately within the wider system risk processes. It was recognised that maternity risks were often complex and multifaceted, and that the system needed to ensure that they were visible at Board level and supported by clear mitigation plans. The Committee agreed that the LMNS enhanced approach to risk identification would support this alignment.
- The Committee emphasised the need for the LMNS to continue strengthening its capability to support providers, particularly in areas where improvement has stalled or where risks have escalated. It was agreed that the LMNS should maintain close engagement with regional colleagues to ensure that system-level support was aligned with national priorities and that providers received the guidance required to meet expected standards.

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
QU10, 17 Safeguarding	Provider trust specific and Initial Health Assessment performance reviewed and actions agreed

Corporate Risk Register risks	
QU 21 AACC	Timescale/capacity issues discussed

Board Assurance Framework Risks	
Risk Title	Key actions/discussion undertaken
P4	Maternity Provider capability reviewed by LMNS

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

Meeting of the System Primary Care Committee of NHS Cheshire and Merseyside

Highlight report of the Chair of the Committee

Agenda Item No: **ICB/11/26/26/20**

Committee Chair: **Erica Morriss**

Highlight report of the Chair of the System Primary Care Committee

Committee Chair	*Erica Morriss*
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	*Thursday 15th October*

Key escalation and discussion points from the Committee meeting

Alert

Prescribing Budget Pressure (Month 4)

- **Significant financial risk:** Month 4 (M4) data reveals a continued **overspend** in prescribing, driving severe current and Forecast Outturn (FOT) budget pressures.
- **Mitigating factors:** High-level overspends have been partially offset by local savings.
- **Key cost driver:** Price concessions (lack of available cheaper alternative stock) remain the primary ongoing challenge.
- **Next steps:** Working in close alignment with the Finance and Investment Committee to execute targeted recovery actions.
- **Positive variance:** Prescribing CRES (Cash Releasing Efficiency Savings) continues to exceed its planned target.

Children and Young People (C&YP) Approvals

- **Business cases approved:** Formally approved funding for the continuation of *All Together Smiling* (3 plus 2) and the expansion of existing schemes to include Alder Hey and DHSG.

Advise

Primary Care Strategy & Restructure

- **ICB Restructure:** Provided a progress update to Contractors and Healthwatch, emphasising the rollout of revised structures, relationship building, and an upcoming feedback loop to measure implementation success.
- **Community Pharmacy:** Noted the Cheshire and Merseyside ICB framework supporting the launch of nationally commissioned Community Pharmacy Prescribing Services. Stage one is underway, focusing on approval and onboarding, with future updates for oversight and continuous improvement.

Systems & Operations

- **Referral Management System:** Approved the implementation of a Local Enhanced Service (LES) to incentivise and accelerate system adoption across the ICB. Designed to drive consistency, clinical triage efficiency, and patient experience. Value of **£1.573m** is awaiting final Finance & Investment approval.
- **Primary Care Digital:** Noted the market entry of a new EPR vendor (Medicus) and agreed on a controlled, governed implementation pathway moving forward.

Capital & Finance Allocations

- **26/27 Capital Plan:** Formally noted and approved positions for the **26/27 UMF** and Business-As-Usual (BAU) Capital Plan delivery.
- **25/26 Capital Plan:** Formally noted delivery, governance, value-for-money metrics, and the long-term sustainability of the **25/26 UMF fund**.

Assure

Governance & Committee Oversight

- **System Primary Care Committee TOR:** Approved the revised Terms of Reference (TOR) following an annual review and an update to the ICB Governance structure. The changes ensure the governance framework remains fit for purpose to support statutory responsibilities and strategic objectives.
- **Primary Care Governance restructuring:** Approved proposed changes to transition from nine former place-based groups down to **two new primary care groups**, supported by a revised decision-making matrix - and an additional forum to oversee delivery and strategy. Contractor Groups will continue to be involved as the structure evolves.

Performance & Quality Monitoring

- **Integrated Primary Care Commissioning, Quality and Performance:** Received comprehensive papers detailed against national and local performance priorities. A full metrics evaluation is scheduled for the **December 2026 SPCC** meeting to ensure current action plans robustly support strategic delivery – quality and wider performance teams will contribute to this item reflecting ongoing work underway with other committees and teams.

Financial & Allocation Assurance

- **Primary Care Financials (Month 5):** Noted the Month 5 (M5) financial position, including current and Forecast Outturn (FOT) budgets.
- **Targeted financial reviews:** Held detailed reviews regarding prescribing and dental funding, with an options paper scheduled for the **December 2026 SPCC**.
- **ARRS mitigation:** Addressed below-target uptake of the Additional Roles Reimbursement Scheme (ARRS), with an agreed action plan to communicate the revised specification.

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**
New Entrant EPR Medicus	NHSE Procurement process now in place for 12 months mitigating potential ICB risk.

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
C&YP Strategic Commissioning	Approval of business cases for All Together Smiling for 3 plus 2 years
PCAP	Approval LES - Improved Referral Management System.
PCAP	Community Pharmacy increase in Prescribing
Primary Care Digital	Supporting new entrant Medicus for EPR procurement.