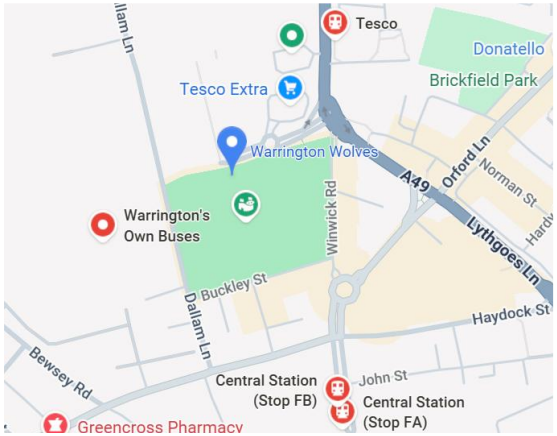
NHS
Cheshire and Merseyside

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

24 July 2025
09:00am

40/Twenty Lounge
The Halliwell Jones Stadium
Warrington Conference Centre
Mike Gregory Way
Warrington
WA2 7NE



Directions:
Entrance to the 40/Twenty Lounge is on Winwick Road, opposite the Red Lion Pub.
Further information on directions can be found at:
https://warringtonwolves.com/tickets-and-hospitality/the-stadium/maps-and-directions/

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. The Board meeting is live streamed and recorded.

Compassionate Inclusive Working Together Accountable

Leading integration through collaboration

Public Speaking Time: 09:00am

Further detail at: https://www.cheshireandmerseyside.nhs.uk/get-involved/upcoming-meetings-and-events/nhs-cheshire-and-merseyside-integrated-care-board-july-2025/

Agenda

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
09:30am	**Preliminary Business**				
ICB/07/25/01	Welcome, Apologies and confirmation of quoracy	Verbal	Raj Jain *ICB Chair*	For information	-
ICB/07/25/02	Declarations of Interest *(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published on the **ICB website**)*	Verbal		For assurance	-
ICB/07/25/03	Chairs announcements	Report		For information	Page 5
ICB/07/25/04	Experience and achievement story	Film	-	For Information	-
09:40am	**Leadership Reports**				
ICB/07/25/05	Report of the ICB Chief Executive	Paper	Cathy Elliott *Chief Executive*	For assurance	Page 8
ICB/07/25/06 **09:55am**	NHS Cheshire and Merseyside Finance Report Month 2	Paper	Mark Bakewell *Interim Director of Finance*	For assurance	Page 39
ICB/07/25/07 **10:05am**	Highlight report of the Chair of ICB Finance, Investment and Our Resources Committee	Paper	Erica Morriss *Non-Executive Member*	For assurance	Page 71
ICB/07/25/08 **10:10am**	NHS Cheshire and Merseyside Integrated Performance Report	Paper	Anthony Middleton *Director of Performance & Planning*	For assurance	Page 74
ICB/07/25/09 **10:20am**	Highlight report of the Chair of ICB Quality and Performance Committee	Paper	Tony Foy *Non-Executive Member*	For assurance	Page 116
ICB/07/25/10 **10:25am**	Highlight report of the Chair of ICB Audit Committee	Paper	Mike Burrows *Non-Executive Member*	For assurance	Page 121
ICB/07/25/11 **10:30am**	Highlight report of the Chair of System Primary Care Committee	Paper	Erica Morriss *Non-Executive Member*	For assurance	Page 126
ICB/07/25/12 **10:35am**	Highlight report of the Chair of the Remuneration Committee	Paper	Tony Foy *Non-Executive Member*	For assurance	Page 130
ICB/07/25/13 **10:40am**	Highlight report of the Chair of the Children's and Young People Committee	Paper	Raj Jain *ICB Chair*	For assurance	Page 133

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
ICB/07/25/14 **10:45am**	Highlight report of the Chair of the Shaping Care Together Joint Committee	Paper	Prof. Hilary Garratt *Non-Executive Member*	For assurance	Page 136
ICB/07/25/14a **10:50am**	Highlight report of the Chair of the North West Specialised Services Joint Committee	Paper	Dr Ruth Hussey *Non-Executive Member*	For assurance	Page 139
ICB/07/25/14b **10:55am**	Highlight report of the Women's Hospital Services in Liverpool Committee Chair of the Committee	Paper	Prof. Hilary Garratt *Non-Executive Member*	For assurance	Page 146
11:00am	**BREAK**				
11:10am	**ICB Business Items**				
ICB/07/25/15	Intensive and Assertive Community Mental Health Care Update	Paper	Simon Banks (Place Director – Wirral)	For assurance	Page 161
ICB/07/25/16 **11:25am**	Developing a framework for Neighbourhood Health Services in Cheshire and Merseyside	Paper	Clare Watson *Assistant Chief Executive* Alison Lee *Place Director - Knowsley*	For approval	Page 174
ICB/07/25/17 **11:40am**	Cheshire and Merseyside Winter Plan 2025-26	Paper	Anthony Middleton *Director of Performance & Planning*	For assurance	Page 205
ICB/07/25/18 **11:55am**	Seasonal Vaccinations: 2024/25 look back and plans for 2025/26 with a spotlight on improving vaccination uptake in Health Care Workers	Paper	Prof Ian Ashworth *Director of Population Health*	For approval	Page 212
ICB/07/25/19 **12:10pm**	Update on improving access to Primary Medical (General Practice) Services	Paper	Clare Watson *Assistant Chief Executive*	For assurance	Page 223
ICB/07/25/20 **12:35pm**	NHS Cheshire and Merseyside 2025-26 Annual Delivery Plan	Paper	Clare Watson *Assistant Chief Executive*	tbc	Page 231
12:50pm	**Meeting Governance**				
ICB/07/25/21	Minutes of the previous meeting: • 29 May 2025 • 19 June 2025.	Paper	Raj Jain *ICB Chair*	For approval	Page 247
ICB/07/25/22	Board Action Log	Paper	Raj Jain *ICB Chair*	To consider	Page 268
12:55pm	**Reflection and Review**				
ICB/07/25/23	Closing remarks and review of the meeting	Verbal	Raj Jain *ICB Chair*	For information	-
13:00pm	**CLOSE OF MEETING**				

Consent items

All these items have been read by Board members and the minutes of the July 2025 Board meeting will reflect any recommendations and decisions within, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.

AGENDA NO	ITEM	Reason for presenting	Page No
ICB/07/25/24	Board Decision Log **(CLICK HERE)**	For information	-
ICB/07/25/25	Confirmed Minutes of ICB Committees: • Audit Committee • Children and Young Peoples Committee • Finance, Investment and Our Resources Committee • Quality and Performance Committee • Shaping Care Together Joint Committee • System Primary Care Committee.	For assurance	**Page 270**

Date and start time of future meetings

25 September 2025, 09.00am, Authority Chamber, No 1 Mann Island, Liverpool, L3 1BP
27 November 2025, 0.900am, Conference Suite, Riverside Innovation Centre, 1 Castle Drive, Chester, CH1 1SL

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

Following its meeting held in Public, the Board will hold a meeting in Private from 13:30pm

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

Report of the Chair of NHS Cheshire and Merseyside

Agenda Item No: ICB/07/25/03

Responsible Director: Raj Jain, ICB Chair

Report of the Chair of NHS Cheshire and Merseyside (July 2025)

1. Introduction

1.1 This report covers some of the work which takes place by the Integrated Care Board which is not reported elsewhere in detail on this meeting agenda.

2. Ask of the Board and Recommendations

2.1 **The Board is asked to:**

- **note** the updates within the report.

3. Key updates of note

3.1 **Southport – one year on.** Board members will recognise that 29 July 2025 will mark one year since the Southport incident and that this will be an incredibly difficult and emotional time for many people affected by the incident.

3.2 As we approach one year on from the tragic events in Southport, we pause to remember the lives of Elsie Dot Stancombe, Bebe King, and Alice Dasilva Aguiar, as well as all those injured and affected by the incident. To mark the day, a three-minute silence will be observed at 3pm on Tuesday 29 July 2025. We encourage all our staff and partners to take part in this moment of reflection. In line with community guidance,[1] we are supporting the call for donations to local causes in lieu of floral tributes.

3.3 The ICB, along with its NHS partners, will continue to collaborate with Sefton Council, to promote psychological support and counselling services for those directly or indirectly affected. A dedicated support page is also available with links to local and national resources.[2]

3.4 We remain committed to supporting all those impacted and to fostering a compassionate, resilient response across Cheshire and Merseyside.

3.5 **Partner Member Update.** I would like to welcome Delyth Curtis, Chief Executive of Cheshire West and Chester Council, as the new Partner Member (Local Authority) on the Board of NHS Cheshire and Merseyside. Delyth has taken up the position following the retirement of Prof. Steven Broomhead.

3.6 **Non-Executive Member Updates**. I have recently received from Neil Large his formal resignation from his Non-Executive Member position on the ICB. This is due to Neil being successful in being appointed formally to the position of Chair of the Countess of Chester NHS Foundation Trust, following a short spell as

[1] https://www.sefton.gov.uk/mysefton-news/latest-news/an-open-letter-to-southport-ahead-of-july-29th-2025/
[2] https://www.sefton.gov.uk/southport-together/

interim Chair since February. I would like to put on record the ICBs gratitude for the support, experience and insight that Neil brought to the ICB since its establishment and wish him well in his role of Chair of the Trust, where we will continue to work closely as system partners to improve the health outcomes and experiences of our local residents.

3.7 With the departure of Neil in February 2025, the ICB progressed the appointment of Mike Burrows as an additional Non-Executive Member for an interim period of six months. With the news of Neils appointment coupled with the current work underway nationally and locally regarding the redesign of ICBs and the recently released 10 Year Plan, it is crucial that we continue to have stability in the Non-Executive leadership on the Board. As such I have agreed with Mike to extend his interim appointment up until the end of June 2026.

3.8 Furthermore, I am also pleased to confirm that Tony Foy has agreed to continue for a second term as a Non-Executive Member of the Board and continue as Deputy Chair of the Board. I am grateful for Tonys continued commitment to the ICB and system and the valuable challenge, experience and enthusiasm he brings to the Board.

4. Fit and Proper Persons Test – Annual Submission 2025

4.1 I can confirm that in line with the requirements of the Fit and Proper Persons Test (FPPT) regulations, that the ICB submitted our FPPT Annual Report to the Regional Director for NHS England North West, to provide assurance that the members of the Board of NHS Cheshire and Merseyside meet the fit and proper persons requirements and fit to continue in role.

4.2 As Board members are aware the purpose of the FPPT Framework, developed in response to recommendations made by Tom Kark KC in his 2019 Review of the FPPT, is to strengthen and reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS. I would like to thank all Board Members for their support towards the completion of this important process.

Contact details for more information

Raj Jain
ICB Chair

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NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

Report of the Chief Executive

Agenda Item No: ICB/07/25/05

Responsible Director: Cathy Elliott, Chief Executive

Report of the Chief Executive (July 2025)

1. Introduction

1.1 This report is the first formal Board report from Cathy Elliott as the new Chief Executive of NHS Cheshire and Merseyside Integrated Care Board.

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

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

2. Ask of the Board and Recommendations

2.1 **The Board is asked to:**

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

3. Setting strategy and delivering long-term transformation

NHS Fit for the Future: 10-Year Health Plan (2025–2035)

3.1 At the start of July 2025, the Government published the 10 Year Health Plan (Fit for the Future)[1] which outlined that the NHS is at a critical turning point. Faced with low public satisfaction, rising demand, ageing populations, long waiting lists, and reduced staff morale, the government has launched this 10-year plan to reform the health service. The plan is based on extensive public and staff engagement which included over 250,000 ideas submitted through the "Change NHS" initiative.

3.2 Within the plan it was outlined that the NHS would be reinvented through the three shifts which have already been widely referenced in recent months:

- **hospital to community - including** a key focus on development of a neighbourhood health service, use of the NHS App and digital solutions to allow patients greater control over their information and access to services, and a growth in personalised care.
- **analogue to digital - i**ncluding a Single Patient Records accessible through the NHS App to become the "front door" to the NHS, use of AI and growth of the Federated Data Platform, to connect information across healthcare settings and reduce clinical administrative time and cost.

[1] https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

- **sickness to prevention - t**he plan focuses on creating a smoke-free generation, tackling obesity, reducing alcohol harm, and eliminating cervical cancer. There is a focus on the Neighbourhood Health Service supporting increased access and uptake of screening services as well as increased use of genomic and predictive analytics to support prevention.

3.3 These will be the core components of our new care model. To support the scale and pace of change to deliver these shifts there would be:

- a **new operating model**, which includes merging NHS England with DHSC, and refocusing ICBs as strategic commissioners, whilst reintroducing earned autonomy for high-performing NHS organisations.
- **Enhanced transparency of quality of care**, includes use of league tables of providers and patient experience measures, revitalising the National Quality Board as the single authority on quality, and use of AI to warn of clinical risk.
- **Workforce transformation** includes career coaching and planning for all staff, AI-enabled productivity, advanced practice roles, more flexible contracts, and technology.
- **Innovation and technology** focuses on five transformative technologies (AI, data, genomics, robotics, wearables).
- **Financial sustainability** includes will take a value-based approach focused on getting better outcomes for the money we spend and clearing deficits through 2% annual productivity gains, multi-year budgets, and innovative capital investment models, alongside linking funding to reported patient experience.

3.4 As well the Executive Summary for the plan there have been a number of organisations who have developed overviews and responses to the plan and a selection of these can be accessed from the links contained within Appendix One.

3.5 Whilst further national detail around how the plan is to be implemented will follow much of it aligns well with our existing work programmes and priorities. Appendix One provides some examples of where we are already aligned in our work. It is proposed that we provide Board with a more complete analysis of the contents of the plan mapped to our existing programmes of work for the Board in September 2025 which will align with our plans to implement the new NHS operating model and ICB Blueprint and how we will develop our capability as a strategic commissioner.

4. Driving high-quality and sustainable outcomes

Marie Curie Hospice Liverpool – Inpatient Bed Closure

4.1 In July 2025, Marie Curie Hospice Liverpool confirmed the permanent closure of its inpatient beds, following a 12-month pause in admissions due to staffing challenges. While the hospice continues to deliver outpatient, wellbeing, and Enhanced Hospice Care at Home services, this decision marks a significant change in the local palliative care landscape.

4.2 NHS Cheshire and Merseyside has consistently supported Marie Curie through continued commissioning and funding uplifts. However, we were unable to meet the provider's request for additional funding beyond the current contract value. The ICB remains committed to ensuring equitable access to Specialist Palliative and End of Life Care (SPEoLC) for residents in South Liverpool. We are working to commission interim inpatient SPEoLC beds from an alternative NHS provider, with the aim of operational readiness by September 2025. We are collaborating with Marie Curie to retain specialist staff expertise and ensure continuity of care.

4.3 We have maintained regular engagement with MPs, local councillors, and the Liverpool Hospice Action Group, who have actively campaigned to retain the inpatient beds. Their input continues to inform our planning and mitigation efforts.

4.4 The sustainability challenges faced by Marie Curie are not unique. A system-wide review of hospice provision and funding is underway, led by the Cheshire and Merseyside hospices collaborative and the ICB's PEoLC group. This work will inform a longer-term strategy to ensure resilient, equitable hospice care across the region.

Measles

4.5 We are seeing a rising number of confirmed measles cases in Cheshire and Merseyside which is putting children and young people at risk within our communities. National Data shows that in the last month, there has been a national increase in measles cases, and that the North West has seen the third highest number of cases in England.

4.6 We are seeing more cases of measles in our children and young people because fewer people are having the MMR vaccine, which protects against measles and two other viruses called Mumps and Rubella.

4.7 Measles is one of the world's most infectious diseases. It is more than just a rash and is a serious risk to those who are unvaccinated. The free MMR vaccine is a safe and effective way of protecting against measles, as well as mumps and rubella. It's important for parents to take up the offer of MMR vaccination for their children when offered at 1 year of age and as a pre-school booster at three years, four months of age.

4.8 If children and young adults have missed these vaccinations in the past, it's important to take up the vaccine now, particularly in light of the recent cases. This can be done by contacting your GP to make an appointment or check to see if the Living Well bus which also delivers routine immunisations including MMR throughout the whole of Cheshire and Merseyside is in your area: https://www.cwp.nhs.uk/livingwellservice

4.9 Anyone with symptoms is advised to stay at home and phone their GP or NHS 111 for advice, rather than visiting the surgery or A&E, to prevent the illness spreading further. Further information about measles including images of a

measles rash and spots in the mouth can be found at https://www.nhs.uk/conditions/measles/

Review of Patient Safety Across the Health and Care Landscape

4.10 On 07 July 2025 Dr Penny Dash's review of patient safety across the health and care landscape in England was published.[2]

4.11 Commissioned by the Secretary of State for Health and Social Care, this review examined how six national bodies contribute to patient safety and how the wider system supports high-quality care. It also assessed the broader landscape of over 40 organisations influencing care quality. The organisations reviewed were:

- Care Quality Commission (CQC)
- National Guardian's Office
- Healthwatch England and Local Healthwatch
- Health Services Safety Investigations Body (HSSIB)
- Patient Safety Commissioner
- NHS Resolution.

4.12 Key findings within the report included:

- the patient safety landscape is fragmented, with overlapping roles and unclear accountability and a proliferation of recommendations—many lacking cost-benefit analysis
- there has been a disproportionate focus on safety over other quality dimensions (effectiveness, user experience, equity), with limited measurable improvement.
- the user voice is underrepresented at board level, despite multiple organisations advocating for patients.
- the complaints system is confusing, with over 70 routes for feedback and limited responsiveness, resulting in patients and staff finding it difficult to navigate the system or raise concerns effectively.
- there is duplication of effort and gaps in intelligence sharing between organisations.
- there is a need for stronger leadership, clearer roles, and better use of data to generate insight and drive safety improvements
- there is no national strategy for quality in adult social care, and data on outcomes is sparse.

4.13 The report provided a number of conclusions, namely:

- a strategic, system-wide approach to quality improvement is needed, balancing all dimensions of care.
- functions should be streamlined and consolidated, especially around investigations and user engagement.
- commissioners and providers must take greater ownership of quality, supported by clearer governance and accountability.
- the CQC should be strengthened as the independent regulator and host for functions requiring independence.

[2] https://www.gov.uk/government/publications/review-of-patient-safety-across-the-health-and-care-landscape

- technology and data must be leveraged to support real-time quality improvement.

4.14 A number of recommendations were also made and which are relevant to the ICB:

- revamp the National Quality Board (NQB) to lead a national strategy for quality, prioritising evidence-based, cost-effective recommendations.
- rebuild CQC's role to focus on governance, board accountability, and sector-specific assessments.
- integrate Local Healthwatch functions with ICBs and provider engagement teams to improve patient and community input into service planning.
- reinforce ICB accountability for commissioning high-quality care, with robust governance, performance appraisal, and learning systems.
- adopt standardised care models and invest in management, leadership, and improvement infrastructure.
- enhance use of data and AI to identify risks, support planning, and evaluate outcomes—building on platforms like the Federated Data Platform.
- streamline staff voice mechanisms, embedding Freedom to Speak Up functions within ICBs and providers.
- support a national strategy for adult social care quality, including consistent metrics and data collection.

4.15 Through the Director of Nursing and Care, Medical Director and the ICBs Quality and Performance Committee, the report and its recommendations will be considered further. The ICB and its system partners will look further into how to implement changes, alongside the work required of the Model ICB Blueprint, and which will be aimed at creating a more coherent and effective patient safety framework. There are a number of key actions for us to progress, the progress of which will be reported back to a future Board meeting, and which include:

- reviewing and aligning local governance structures with national expectations for quality oversight.
- ensuring executive-level leadership for patient experience and staff voice.
- embedding data-driven decision-making and invest in digital infrastructure.
- collaborating with local authorities to support social care quality improvement.
- engaging with the NQB and CQC on the implementation of new frameworks and standards.

Using Data to Improve Health Services in Cheshire and Merseyside

4.16 The ICB is helping to lead a national project to improve how health services are planned and delivered. This work is part of the Federated Data Platform (FDP) initiative, and our region is one of only three areas in England chosen to test a new tool called the Strategic Commissioning Tool (SCT).

4.17 The SCT uses data to help health leaders make better decisions about services, focusing on the needs of the whole population rather than just individual treatments or conditions. It's designed to support smarter, more joined-up planning across local areas.

4.18 The project began in early 2025 and is being led by Carl Marsh, Place Director (Warrington) with clinical leadership input from both Warrington and Liverpool Clinical Directors, and with input from public health, finance, and other key teams. The first version of the tool was launched in June this year and is already being used to support local care models.

4.19 The SCT work sits within the Data Into Action programme governance which has used its resources to support local evaluation and change management for the roll out of the SCT, with considerable input from our partners at Health Innovation North West Coast.

4.20 We are also developing a Neighbourhood Academy Programme to help local teams and partners use the tool effectively. Future updates will include advanced features like AI-powered evidence libraries and tools for comparing population health data and planning different scenarios. We are confident that the additional functionality will help equip the ICB with the insight needed to support strategic planning and resource optimisation.

4.21 This work is part of our commitment to using data to improve health outcomes and make the best use of resources across Cheshire and Merseyside.

Community Diagnostic Centres reach key milestones

4.22 The Cheshire and Merseyside Community Diagnostic Centre (CDC) Network hit a major milestone in their CDC programme recently by welcoming the millionth patient to receive a test in one of the 10 CDCs in Cheshire and Merseyside.

4.23 David Titchfield, from Lymm, was the millionth patient to be treated at a CDC in Cheshire and Merseyside after he attended the Warrington and Halton Diagnostics Centre on Monday 16 June.

4.24 This year Cheshire and Merseyside CDCs are expected to deliver testing for nearly half a million patients as we continue to offer more testing options and locations, including the most recent addition to the CDC family, the Warrington and Halton CDC which officially opened on 16 June 2025. To add to the list of milestones for CDCs, Paddington Community Diagnostic Centre (CDC) has reached its second major milestone welcoming the 50,000th patient to receive an examination at the centre since it opened almost two years ago.

4.25 Each CDC can provide a range of diagnostic tests across endoscopy, imaging, physiological measurements, pathology, dermatology to name a few, and often patients will be able to have multiple tests during one visit to improve speed of diagnosis and convenience.

4.26 Over 250 new jobs have been created in our local CDCs allowing for better opportunities for staff rotation, training, and development as well as allowing services to develop new services and ways of testing such as straight-to-test facilities for primary care to refer into.

Cheshire and Merseyside Risk Summit 21 July 2025

4.27 "The patient at highest risk is the one in the community waiting for an ambulance." Delays in ambulance response times are a known source of harm, yet this risk is not consistently shared across the system—from the community to hospital and on to discharge.

4.28 The ICB is hosting a Cheshire and Merseyside system Risk Summit on the 21 July 2025. This Risk Summit brings together leaders from ambulance services, community and acute care, and social services to explore how we can collectively manage this risk. Key questions include: *How do we prevent avoidable admissions by strengthening care at home? How can we make more confident discharge decisions when emergency departments are under pressure? And how do we support staff to act decisively within a shared, system-wide safety net?*

4.29 The summit will consider data, evidence, and real-world examples to develop actionable plans tailored to local needs. Participants will hear from national and local experts and take part in workshops to co-produce solutions that reflect the diversity of our geography, populations, and staffing models.

4.30 By improving how we share risk and coordinate care across settings, we can make safer, faster decisions and ensure patients get the right care in the right place—while relieving pressure on emergency services. The Board will receive an update on the summit at its meeting this month.

5. Providing robust governance and assurance

Financial Recovery Update

5.1 On the 19 May 2025 NHS England (NHSE) issued a letter to the system signalling its intent to place it in 'turnaround'. This was on the basis of an assessment of overall financial risk for the 25/26 financial year (FY), the failure to deliver its financial plan for the past two financial years and relative size of the underlying deficit.

5.2 The letter mandated a rapid diagnostic review which sought to build on work already being undertaken to date within Cheshire and Merseyside and to identify immediate recommendations to enhance the FY25/26 financial plan delivery in order to inform the turnaround approach. This diagnostic review, undertaken by Price Waterhouse Cooper (PwC), took place over a few weeks, starting in mid-May this year, with high-level findings being shared with both the ICB and NHSE during early July. Following receipt, the ICB hosted with PwC and NHSE regional colleagues a virtual briefing on 4 July 2025 on the executive summary report of the diagnostic for all our system NHS Trust Chairs, Chief Executives, Directors of Finance and ICB NEDs, alongside the ICBs Executives. The intention was to ensure a common understanding across the system's leadership of the findings, the expectations of NHSE region, PWC's next phase of work and to clarify system financial aims and next steps.

5.3 The review recommended the following

- implementation of an enhanced local 'System Oversight framework' to enhance the rigour by which financial plans are being overseen, thus improving the transparency of delivery, along with seeking to better identify and mitigate risks to the plan. (It should be noted that this is separate and distinct from the recently announced NHSE oversight framework).
- to supplement the System Oversight Framework (and to provide the system with clarity on the starting point and where to target effort) the system would benefit from a developing shared understanding of the financial baseline, a detailed assessment of grip and control where run-rate pressures are evident, and, for organisations with robust balance sheets, a detailed assessment into potential balance sheet mitigations that the System could leverage (subject to organisational authorisation).

5.4 In addition to this, the system is already reviewing its approach to improve systems arrangements particularly with the regards to consistency of reporting, approaches to forecasting and the development / monitoring of efficiency savings within and across the organisations within the system. Thanks to leaders in NHS providers and the ICB who are responding to this priority recovery work for the system.

Industrial Action

5.5 The BMA has formally advised that resident doctors will have the option of participating in industrial action during a period of 5 consecutive days from 7am on the 25 July 2025. The ICB and NHS providers have a tried and tested incident plan specific to industrial action and have immediately enacted the plan to prepare for action, response during the period and the recovery stage afterwards, working with NHSE regional colleagues.

6. Building a trusted relationship with partners and communities

Southport Inquiry now launched

6.1 As you will likely already be aware, last week saw the opening of the Southport Inquiry, looking into the attack by Axel Rudakubana.

6.2 The proceedings are being chaired by Sir Adrian Fulford at Liverpool Town Hall. He explained that the inquiry would be held over two phases: the first will thoroughly investigate the circumstances surrounding the attack and the events leading to it; and the second is expected to examine the broader issues of children and young people being drawn into extreme violence.

6.3 The hearings began last week and are now taking a break. They are due to resume in September this year with further impact statements from the victims and their families.

6.4 Phase one of the inquiry is due to be completed, and findings published by the end of the year. Those findings will then form the terms of reference for the second phase, starting and finishing in 2026.

6.5 The ICB, along with its NHS partners, will continue to collaborate with Sefton Council, to promote psychological support and counselling services for those directly or indirectly affected. A dedicated support page is also available with links to local and national resources.[3]

Abolition of Integrated Care Partnerships (ICPs)

6.6 Following the publication of the new Ten-Year Health Plan and the English Devolution White Paper, a ministerial letter from the Minister of State for Health, Karin Smyth, confirmed that ICPs will no longer be a statutory requirement and are therefore to be abolished (Appendix Two). This has prompted a significant shift in governance planning across Cheshire and Merseyside.

6.7 In light of this announcement, the planned July 2025 meeting of the Cheshire and Merseyside Health and Care Partnership (HCP) was cancelled to reflect on the announcement. The focus has now shifted to planning how the Marmot “All Together Fairer” ambitions can continue to be delivered through Local Authority Health and Wellbeing Boards and the strategic Mayoral Combined Authorities - Liverpool City Region and the emerging Cheshire & Warrington strategic authority. We will continue to keep Board informed of developments.

Cheshire and Warrington Strategic Authority

6.8 Local council leaders in Cheshire East, Cheshire West and Chester, and Warrington have formally requested to Government a 12-month delay to the planned May 2026 mayoral election for the new Cheshire and Warrington Strategic Authority (Appendix Three). If approved, the election would now take place in May 2027, aligning with other local elections in the region.

6.9 The delay is intended to allow more time to establish the necessary foundations for the new devolved authority and ensure a smooth transition to a metro-style mayoral system. Leaders argue that this would also help reduce costs and boost voter turnout.

6.10 The proposed devolution deal would grant the region greater powers and funding from central government, similar to arrangements in the Liverpool City Region. However, the plan still requires approval from the Government and formal votes by the three councils, expected in September 2025

6.11 The ICB will continue to work with our partners across the three Cheshire and Warrington Councils in supporting their plans for a Strategic Authority and the implications that this may mean for health and care, as well as the implementation of the NHS 10 Year Plan.

[3] https://www.sefton.gov.uk/southport-together/

VCFSE Engagement

6.12 As the ICB pushes through a significant reform process the relationship with its key partners it vital. Over the last few years an infrastructure approach has been developed, tapping into the expertise of our leaders in the voluntary, community, social enterprise and faith (VCFSE) sector, securing seats at influential meetings and ensuring the voice of our communities' ring through our co production.

6.13 At a recent meeting with the place/systems leaders of the VCFSE sector I supported and endorsed the approach. Following this the partnership is now working on a Memorandum of Understanding (MOU) between the ICB and VCFSE sector to further galvanise this relationship.

6.14 Areas aimed to be covered in the MOU are:

1. Support VCFSE voice, representation and engagement with C&M ICS
2. Embedding the VCFSE as a key delivery partner in C&M workstreams
3. Support and champion VCFSE role in Cheshire and Merseyside's nine places
4. Maximising the economic opportunities highlighted in 'The state of the sector' report.
5. Enhancing ongoing work
   - Embedding VCFSE in 'neighbourhood health'
   - Establishing a system wide VCFSE hospital discharge model
   - Maximising the potential of VCFSE prevention programmes
   - Securing fairer, equitable and sustainable funding for the sector
   - Co-producing services in their design and delivery
   - Supporting children and young people
   - Developing our workforce
   - Making full use of healthcare data.

6.15 I will bring further updates to the Board on the progress of the MOU.

6.16 At this meeting I also invited and secured VCFSE representation to help join our working groups developing the neighbourhood health model across Cheshire and Merseyside.

7. Creating a compassionate, just and positive culture

Workforce support in Response to the Model ICB Blueprint

7.1 The Model ICB blueprint issued by NHSE on 2 May 2025 outlined a significant transformation agenda for ICBs, including the transfer, streamlining or reconfiguration of multiple functions such as safeguarding, SEND, digital leadership, and primary care operations. The Blueprint aims to reduce operating costs while enhancing population health management and neighbourhood-based care delivery.

7.2 Considerable work is underway to redesign the operating model of the ICB as well as engaging with staff regarding the implications of the running cost reductions and redundancies that will result.

7.3 As an ICB we have undertaken a number of key activities in response to the Blueprint, including:

- **Staff Briefings**: Regular updates are being provided, including sessions such as “We Are One” to ensure transparency and support
- **Engagement Roadshows at ICB Offices**: Delivered during this month to facilitate two-way dialogue and gather feedback pre-consultation.
- **Trade Union Involvement**: The ICB has strengthened its partnership working arrangements with local trade union representatives with regular meetings and active engagement
- **HR Guidance**: Developed manager toolkits and one-to-one templates to support staff through the change process.
- **Staff Hub Resources**: FAQs and support materials have been created and are regularly updated and accessible to all staff.
- **Wellbeing support offers** – The ICB has implemented a range of wellbeing offers to support staff through the transition. These initiatives are designed to address the pressures of organisational change whilst promoting resilience and mental health across the workforce. These include access to health checks, counselling and occupational health support, as well as self-care, wellbeing and financial matters (including understanding pensions) webinars
- **Career support offers –** The ICB has made available a range of support offers that include webinars on CV skills, interview techniques, leadership development, people management skills and other career management support offers.

7.4 Staff are being regularly kept up to date as to when the staff consultation will commence. Once it commences it will be run for a 45-day period when there will be further opportunities for staff to have 1-1 with their managers, attend group meetings and consultation roadshow meetings. Our support to staff to manage their wellbeing will continue during that time.

Child Death Framework for General Practice

7.5 In a pioneering move, NHS Cheshire and Merseyside has published new guidance designed to equip general practice teams with the tools and understanding to support bereaved families following the death of a child.

7.6 *When a Child Dies: An NHS Cheshire and Merseyside Framework for General Practice*[4] was produced in collaboration with The Alder Centre – a dedicated child bereavement centre based at Alder Hey Children’s Hospital – and Claire House Children’s Hospice.

7.7 Published to coincide with the inaugural Child Death Awareness Week (1 to 7 July), the framework recognises that, while healthcare professionals are experienced in dealing with loss, child deaths are deeply traumatic and often occur under sudden or complex circumstances, presenting unique clinical and emotional challenges.

[4] https://www.cheshireandmerseyside.nhs.uk/latest/publications/guidance/child-death-framework/

Start of Shaping Care Together Consultation

7.8 At its meeting in public on the 4 July 2025,[5] the Shaping Care Together Joint Committee received and approved the Pre-Consultation Business Case (PCBC) which outlined the case for and recommendations regarding proposed options relating to changes to local urgent and emergency care services in Southport, Formby and West Lancashire. In approving the PCBC the Committee, on behalf of the ICB and NHS Lancashire and South Cumbria ICB, approved the commencement of a 13-week public consultation (from 4 July 2025).

7.9 Further details about the proposals, how to take part in the consultation and dates for engagement events can be found at https://yoursayshapingcaretogether.co.uk/

Update on Fertility Consultation

7.10 Following a six-week period the consultation on the harmonisation of the Cheshire and Merseyside fertility treatment policies closed on the 15 July 2025. The ICB received over 2,000 responses to the consultation. As is the duty of the ICB, over June and July this year the ICB engaged with the nine Local Authority Health and Overview Scrutiny Committees in relation to the consultation which has resulted in the requirement for the ICB to formally consult with the Health Scrutiny Committees. As such, a Joint Health Scrutiny Committee is to be formed and the ICB will work with the Committee to agree the dates as to when the ICB will consult with the Committee.

7.11 During this time the ICB will analyse the responses to the consultation, and following consultation with the Joint Health Scrutiny Committee, will look to bring recommendations to the Board at its November 2025 meeting.

8. Promoting equality and inclusion, and reducing health and workforce inequalities

Showcasing our unique model – All Together Fairer

8.1 The institute of Health Equity have published their latest report showing the unique public health system model across Cheshire and Merseyside being an "exemplar" for a Marmot Subregion - **'All Together Fairer for Health Equity: Champs Public Health and the IHE'.** The report highlights that Cheshire and Merseyside "***stands out as a region that has moved beyond strategy into collective action on health inequalities"***. It also shares how All Together Fairer has supported the further development of a strong partnership between NHS and local authority as well as supporting local leadership to translate the Marmot principles into local action.

Smoking at time of delivery rates reduces to below national target

8.2 New data released on the 19 June 2025 showed that the number of women in Cheshire and Merseyside smoking during pregnancy has sharply declined. Thanks to excellent system effort across the region, the rate of

[5] https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/shaping-care-together-joint-committee/4-july-2025/

expectant mothers smoking has dropped from 10% to 6.5% in just two years, helping to close the gap with the national average of 6.1%. In Q4 24/25 the rate was down to 5.6% exceeding the national target of 6%.

8.3 The figures highlight a clear improvement in the number of women quitting during pregnancy, following a system-wide initiative to engage with mums-to-be. Part of the All Together Smoke Free Programme, the Smoking in Pregnancy (SiP) project supports women on their 'quit journeys', creating a tailored plan to help treat smoking addiction and delivering smokefree families and fairer, healthier futures.

8.4 Smoking is the single most modifiable risk factor in pregnancy, causing 5,300 foetal/peri-natal deaths each year across the country. It also leads to 2,200 premature births and 19,000 low birth weight babies.

National Child Poverty Unit to visit Cheshire and Merseyside

8.5 In collaboration with the Cheshire and Merseyside's Directors of Public Health, the system has prioritised tackling child and family poverty. A 2023 situational analysis and shared framework for action commits to the ambition that **no child grows up in poverty**. This visit follows an invitation from the Champs Directors to the National Child Poverty Unit (CPU), as part of local efforts to influence national strategy. The CPU have welcomed the opportunity to hear directly from children and their families in Cheshire and Merseyside and meet with key system leaders. The visit will be hosted by Sefton Place on 22 July 2025.

Breastfeeding and Infant Feeding Strategy

8.6 NHS Cheshire and Merseyside Local Maternity and Neonatal System has launched a new Breastfeeding and Infant Feeding Strategy.[6] This new strategy outlines our commitment to improving breastfeeding rates across Cheshire and Merseyside - particularly the duration of exclusive breastfeeding to six months which has the potential to significantly enhance the health and wellbeing of both mothers and babies. In doing so, we aim to reduce health inequalities and the long-term demand on health and care services.

8.7 Co-produced with partners and shaped by the lived experiences of parents, carers, health professionals and community organisations, the strategy is built around five key priorities:

- Seamless support
- Information and education
- Equality and accessibility
- Collaboration and workforce
- Implementation and improvement.

8.8 These priorities will guide how we improve support for families at every stage - from pregnancy through to early infancy and beyond. Our approach recognises that all parents and carers need timely, consistent and culturally competent support to feed and care for their infants in ways that are right for them.

8.9 To view a copy of the Breastfeeding and Infant Feeding Strategy go to: https://www.cheshireandmerseyside.nhs.uk/latest/publications/plans-and-strategies/breastfeeding-and-infant-feeding-strategy/

Anchor Charter Success

8.10 We are delighted to announce that the University of Liverpool has become the first educational institution to sign the Cheshire and Merseyside Integrated Care System (ICS) Anchor Charter. The Anchor Charter[7] sets out a shared commitment by local organisations to use their influence and resources to benefit the health, wellbeing, and prosperity of our communities.

8.11 By signing the Charter, the University of Liverpool has joined a growing movement of organisations working together to tackle health inequalities, create inclusive local employment, and drive sustainable economic and environmental outcomes.

8.12 This is a landmark moment for the Anchor Charter and our ICS, as it marks the first time a university has formally committed to acting as an anchor institution alongside NHS organisations and local authorities. It recognises the important role that higher education plays in our region – not only through research and education, but also as a major employer, procurer, and civic leader.

8.13 We look forward to working in partnership with the University of Liverpool to create a fairer, greener, and healthier future for Cheshire and Merseyside.

9. Decisions taken at the Executive Committee

9.1 At its meetings throughout June and July 2025, the Executive Committee has also considered papers and made decisions on the following areas:

- **Marriss House** – the Executive Team approved the extension of the lease agreement for a further 6 months at Marriss House (Wirral Place)
- **Halton Place Staff Consultation - Runcorn Town Hall** – the Executive Team approved the consultation document with affected Halton Place staff regarding the planned closure of the ICB base at Runcorn Town Hall and transfer of contractual base to No 1 Lakeside, Warrington.
- **Inflationary Uplifts** – the Executive Team received a paper on and approved inflationary uplift proposals for services not covered by an NHS mandated service unit price.

9.2 Additionally at its meetings throughout June and July 2025, the Executive Committee has also considered papers on or discussed the following areas:

- Annual Report and Accounts 2024-25
- Activity Planning Assumptions
- Referral Management System
- Better Care Fund
- 2025/26 Winter Planning
- NICE Technology appraisals

[7] https://www.cheshireandmerseyside.nhs.uk/about/sustainability/anchor-institution-framework/

- Model ICB Blueprint and restructure
- CSU Contracting
- Mental Health Teams in Schools
- Neighbourhood Health Framework
- AACC Improvement Plan Update
- Discharge and Choice Policy
- Medicines Management.

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

10. Officer contact details for more information

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11. Appendices

Appendix One: Population Health and NHS 10 Year Plan

Appendix Two: Letter from Karin Smith MP to ICP Chairs

Appendix Three: Cheshire and Warrington Devolution Letter

Appendix One to Chief Executive Report:

NHS Cheshire and Merseyside – Examples of alignment with the Ten-Year Health Plan

NHS Cheshire and Merseyside Joint Forward Plan reflects our existing Population Health Partnership Plan and our All Together Fairer (Marmot) Health and Care Partnership Plan and demonstrates a strong alignment to many of the priorities laid out in the Ten-Year Health Plan and provides the ICS with the foundations to drive better health outcomes for our residents.

This briefing summarises some examples of each shift and where our future focus needs to be from a population health and prevention perspective.

1. Hospital to Community

1.1. What are we doing now?

1.1.1. As part of delivering a successful Neighbourhood Health Service, one of the core components to this is the use of Population Health Management tools in helping improve strategic commissioning and proactively support patients who are at greater risk of future health care interventions and where early intervention and support could be put into place to improve long term prevention of ill health.

1.1.2. In the last year, we have successfully established our Population Health Academy with our partners in Health Innovation North West Coast and University of Liverpool. Many of our Places are now maximising the use of Enhanced Case Finding tools as part of our neighbourhood approach helping to prevent CVD, and more effectively support Complex households, and high intensity users of health care services.

1.1.3. C&M has been a national leader and won awards for its population health management platform (CIPHA) and associated PHM approach. Due to Cheshire & Merseyside's maturity in creating data linked assets and our established Data into Action Programme, we were selected as one of three sites nationally to develop the National Federated Data Platform (FDP) Strategic Commissioning Tool. This aims to empower ICBs everywhere with proactive, data-driven insights, supporting a shift from transactional, service and disease centric commissioning towards strategic, population level commissioning. In addition, we are developing a Secure Data Environment (SDE) to enable appropriately secure and confidential data to be available for research and innovation purposes.

1.1.4. We have existing development plans to support improvements in access and care in Primary Care across the different sectors (General Practice, Dentists, Community Pharmacy and Optometry). This includes training more GPs, and digital solutions. We have been at the forefront of work on reducing inefficiency and red tape in relation to work on the interface between primary and secondary care services. Dental improvement plans are improving access and we have also implemented several national access schemes in community pharmacy e.g. Pharmacy First.

1.2. **What are we developing?**

1.2.1. Neighbourhood Health Models including “Prevention in Neighbourhood Health” – key to achieving the move from sickness to prevention will be embedding prevention within the neighbourhood models. We are planning how we reduce the prevalence of smoking, unhealthy weight, unsafe alcohol consumption and inactivity in our currently healthy population, our population with undiagnosed or early diagnosis of chronic conditions and those with multiple chronic conditions through the role of Neighbourhood Health Teams and wider multi agency partnerships

1.2.2. Waiting well – embedding assessing, advising, recording and referring patients for the four main modifiable risk factors from the point a patient is placed on a diagnostic pathway to ensure their health and wellbeing is optimised if they need treatment, but this work continues as they move through the pathway including while on waiting lists. Ambitions to offer interventions to those currently on waiting lists based on their smoking status.

1.3. **What do we need to work on next?**

1.3.1. ICBs will be critical to establishing better partnerships with local government and the national aim is adjust boundaries to match those of new combined authorities and that ICBs should be coterminous with strategic authorities, wherever feasibly possible. Our ICB has been in developed engagement around establishing the potential for the HCP to be aligned across the two footprints of Liverpool City Region and Cheshire and Warrington, however Integrated Care Partnerships are now to be abolished as part of the Ten-Year Health Plan.

1.3.2. In the future, a neighbourhood health plan will be drawn up by local government, the NHS and its partners at single or upper tier authority level under the leadership of the Health and Wellbeing Board, incorporating public health, social care, and the Better Care Fund.

1.3.3. The ICB will bring together these local neighbourhood health plans into a population health improvement plan for their footprint and use it to inform commissioning decisions.

1.3.4. Additional work will take place with the Local Government Association to consider democratic oversight and accountability of the new NHS operating model, the role of mayors and reforms to local government. Where devolution and a focus on population health outcomes are most advanced, work will take place with strategic authorities as prevention demonstrators.

1.3.5. The importance of all partners including all four Primary Care contractor groups being part of the neighbourhood health model is recognised including ensuring access to relevant patient information to support clinical care.

1.3.6. Building on existing work we know we have more to do to maximise the benefits of the investment in dedicated mental health emergency departments to ensure patients get fast, same-day access to specialist support in an appropriate setting alongside assertive outreach care and treatment.

2. Analogue to digital

2.1. What are we doing now?

2.1.1. Digital and data has a strong theme throughout the 10 Year Plan, not only with its own section on the shift from 'Analogue to Digital', but also a strong presence in other chapters such as Neighbourhood Health Development and the section on the 'five big bets' (which includes data, AI, robotics, wearables and genomics developments).

2.1.2. C&M is in a good position to build on existing work and exploit / maximise the opportunity arising from many of the key digital areas outlined in the plan. These include:

2.1.2.1. **Expansion of the functionality and application of the NHS App to truly become the 'digital front door' to the NHS** – C&M has:

- Targeted support into General Practice to enable higher uptake of key NHS App functions by patients compared to many other ICBs
- Undertaken pro-active work to address digital exclusion and provide a range of accredited apps to patients to support LTC management
- Increased the integration of acute and specialist Trusts' local patient portals with the NHS App, making it more meaningful to access for patients as their 'digital front door' and in support of the Elective Recovery agenda.

2.1.2.2. **Rollout of a national Single Patient Record to give patients control over a single, secure and authoritative account of their data** – C&M has invested over several years in Shared Care Records, enabling information from multiple health and care settings to be shared with others involved in the care of a patient. The current programme of work to rationalise the Shared Care Record system estate to a single Shared Care Record system, and expand its use across Places, puts it in a good position to align with any future national Single Patient Record system development

2.1.2.3. **Procurement of a single digital platform to support Neighbourhood Health** – C&M is fairly uniquely positioned to be a 'trailblazer' in this space due to the 'at scale' test of change currently on-going with the Blinx PACO platform that delivers much of the functionality required for a Neighbourhood Health platform

2.1.2.4. **Expansion of the use of AI and Automation** – C&M is currently:

- Piloting Ambient AI scribes in many NHS Providers and in primary care to improve productivity in clinical consultations
- Routinely using AI in various clinical networks including CAMRIN for imaging review
- Deploying Automation technologies (such as RPA – Robotic Process Automation) into several 'back office' and clinical efficiency areas

2.1.2.5. Digital and data capabilities underpin the ambitions set out in the 10 Year Plan. Although a detailed operating model for digital and data to serve these ambitions is still evolving, Cheshire & Merseyside is well positioned to build on existing local collaborations as well as new opportunities aligned with an emerging national infrastructure. The ICB has established a system wide Enterprise Architecture function and associated governance which will provide a shared blueprint for all digital investments over the period of the plan. This will ensure a standard approach to new technology adoption, which observes agreed clinical safety and interoperability standards and delivers financial value through investment at scale in shared products where appropriate. The adoption of this single blueprint will be a key enabler for coherent digital enablement of new models of care.

2.1.3. Across our prevention and population health programmes we have been seeking to maximise the improvement of digital health offers. This includes our Lower My Drinking App based intervention for harmful and hazardous drinkers to support them to begin to move towards drinking within safer levels, and as part of our Smoking Ends Here ambitions for digitised support to help end smoking everywhere for everyone.

2.1.4. We have also been working with our partners to help recognise inequalities in access to technology and how we can communicate and engage much better with our communities, to reduce the risk of digital exclusion. Our work through Data into Action has led to improvements in the use of Telehealth and combining our data with partners to help improve families who are at risk of fuel poverty.

2.1.5. The ICB is working closely with our academic partners and LCR Combined Authority which has seen the introduction of LCR Residents Assembly on gaining greater understanding and insights from our residents on the safe and effective use of Data and Artificial Intelligence.

2.2. **What are we developing?**

2.2.1. Digitalisation of the assessment and referral for modifiable risk factors across the NHS within the single patient record – agreeing what assessment tools should be used, ensuring these are integrated into digital templates and connecting system to enable electronic referrals into lifestyle pathways

2.2.2. Creating opportunities for residents to receive preventative interventions digitally – smoking cessation delivered via an app

2.3. **What we need to work on next?**

2.3.1. Ensure prevention is a key component of the single patient record – modifiable risk factors, falls and frailty, vaccination uptake, screening uptake.

2.3.2. Consider how we use behaviour change methodology to ensure patients adopt the NHS App as the tool for patient choice – many factors influence the choices patients make and the options they choose how can we use our expertise to ensure patients make the right choice.

2.3.3. As part of the evolving National plans for the NHS app to be a leading tool for patient access, empowerment and care planning it will see new features introduced that the ICB will need to plan for, these include.

- To get instant advice for non-urgent care, and help finding the most appropriate service first time, through My NHS GP
- choose their preferred provider, whether because it delivers the best outcomes, has the best feedback or is simply closer to home, through My Choices
- book directly into tests where clinically appropriate through My Specialist, and hold consultations through the app with My Consult
- manage their medicines through My Medicines and book vaccines through My Vaccines
- manage a long-term condition through My Care, access and upload health data through My Health or get extra care support through My Companion
- manage their children's healthcare through My Children, or co-ordinate the care of a loved one or relative through My Carer

2.3.4. The national intention is for the App to give patients the option to leave feedback on the care they receive, that can be viewable by others, nationally collated and translated as actionable recommendations to providers and clinicians to support continuous improvement.

2.3.5. As part of these plans Healthwatch England, working with local Healthwatch organisations, is proposed to be abolished and to bring patient voice 'in house' - to give it a greater profile within a reformed Department of Health and Social Care. A new National Director of Patient Experience will be created that will incorporate the functions of Healthwatch England, as well as the work on patient experience adopted by the Patient Safety Commissioner (PSC). The work of local Healthwatch bodies relating to healthcare will be brought together with ICB and provider engagement functions. Local authorities will take up local Healthwatch social care functions.

3. Sickness to Prevention

3.1. What are we doing now?

3.1.1. There is very strong alignment with our existing population health at scale ambitions, with that of the Ten-Year Health Plan on prevention. It outlines the Marmot principles that we have seen create our own unique All Together Fairer Partnership Plan, to act on social, economic and commercial determinants of health and to half the gap in healthy life expectancy between the richest and poorest regions.

3.1.2. It aims to empower the public, politicians and professionals to make a shift to a preventative model of physical and mental health a reality. A more preventative model of care delivered at neighbourhood level, and the enhanced role of strategic authorities, will support the development of cross-sector partnerships that are rooted in communities, that can be supported by pooled budgets.

3.1.3. In relation to Children's Mental Health our Mental Health and Beyond Programmes are focused on some key aspect of the Plan already, including:

3.1.3.1. Continued expansion of mental health support teams (MHSTs) in schools and colleges

3.1.3.2. Embedded support for children and young people's mental health in new Young Futures Hubs, alongside a wellbeing offer, to ensure there is no 'wrong front door' for people seeking help.

3.1.3.3. Improve access to specialist mental health services for children and young people (and adults) to reduce long waits

3.1.3.4. *We have existing work through Appropriate Places of Care working group.*

3.1.3.5. To ensure that children with the most complex mental health needs in residential care get the treatment and support they need to avoid even more expensive hospital admissions and repeated emergency department visits.

3.2. What are we delivering and developing?

3.2.1. All Together Fairer and Child Poverty: Through our HCP Headline ambition, to tackle child and family poverty, our research (led jointly with public health teams) has been able to advocate for the importance of policies to tackle child poverty and the significant health impacts that deprivation drives on our health. This has attracted the first visit in England from the new Child Poverty Unit which is due in July, and the Ten-Year Plan states it will restore the value of the Healthy Start scheme and expansion of free school meals.

3.2.2. The All Together Smiling Supervised Tooth brushing programme is also targeted at the most deprived communities across all of Cheshire and Merseyside. This has placed us in an advanced position to enhance our

children's oral health with the national announcement to build on the supervised toothbrushing programme and expand the use of fluoride varnish and fissure sealants, and community water fluoridation schemes to significantly reduce decay.

3.2.3. All Together Smokefree. The Ten-Year Health Plan priorities include creating a smoke free generation for a smoke-free UK, part of this will be through The Tobacco and Vapes Bill will halt the advertising and sponsorship of vapes and other nicotine products. Our ICB and Nine Local Authority Directors of Public Health were one of the first systems nationally advocating for this action to help prevent harm to our children and young people. The ICB are leading the investment in taking a whole system approach to delivering on the Cheshire and Merseyside ambition of ending smoking everywhere for everyone by 2030. This programme includes a systematic programme of collaboration with our nine local authorities and all our NHS Trust's Treating Tobacco Dependency services.

3.2.4. Healthy Weight: A whole system approach to overweight and obesity - This would ensure those patients who have successfully achieved a healthy weight through NHS funded weight loss drugs are able to sustain this weight loss by moving from an obesogenic environment to one that makes the healthy choice the easy choice. The Government intend to restrict junk food advertising targeted at children, ban the sale of high-caffeine energy drinks to under-16-year-olds, and use our revised National Planning Policy Framework to give local councils stronger powers to block new fast-food outlets near schools. Through the work of our HCP, most of our local authorities have now adopted a Healthy Food Advertising policy across their estates, working with new Strategic Authorities on their bespoke health improvement duties will enable our system to maximise innovations like this even further.

3.2.5. Housing and Health Collaborative: Having introduced our new collaboration between Health and Housing Providers from across Chesire and Merseyside, this partnership will help support key elements of the new national plan. This includes action to improve the standard of rented home, tackling damp and mould, which can cause respiratory illness and other health problems. The Department for Energy Security and Net Zero (DESNZ) is also leading the development of an ambitious new Warm Homes plan and Fuel Poverty Strategy, backed by £13.2 billion of investment to help make homes warmer, more comfortable and energy efficient. DESNZ will work with the Department of Health and Social Care to help ensure more health-vulnerable households get the help they need to improve their homes.

3.2.6. Work and Health within Devolution - NHS Cheshire and Merseyside, Liverpool City Region Combined Authority (LCR CA) and Enterprise Cheshire and Warrington are working together with Local Authorities, NHS commissioners, the VCFSE sector and providers on the development of a work and health strategy. This work has multiple aims of improving the health of our population and the workforce and supporting economic growth. The initial draft of the Strategy was delivered on Friday 4th July.

This is directly informing the local Get Britain Working Plans and strengthening the collaboration with our Strategic Authorities. Funding is also in place to expand the employment advisor roles from Talking Therapies services to MSK services. Further funding has also been applied for to implement an employment programme for Housing provider tenants to create opportunities for employment within the NHS. This work helps to ensure that the relationship between health and economic prosperity is clearly understood and opportunities to work collectively on developing solutions to this challenge are optimised.

3.2.7. Driving Local Economic Value and Social Equity: NHS Cheshire & Merseyside and its partners generated £94.3 million in social value from 2022–202 using a bespoke TOMs framework that places heavy emphasis on local jobs, skills, environmental sustainability, and community innovation. Our anchor institution approach is unique in the UK: we co-developed a Social Value Charter and Anchor Framework with councils, NHS trusts, VCFSEs, and business, with 80+ organisations signed up to the social value charter and 70 awarded quality marks for delivering real living wage, local procurement, community asset use, and net-zero pledges. The development of an 'anchor activity' dashboard with the Centre for Local Economic Strategies (CLES) provides a clear, real-time overview of activity, progress and impacts - 92% of our Anchor organisations' workforce reside in C&M – of these 99% are paid the Real Living Wage. The new National Plan sets a greater expectation on hospitals to do more as anchor institutions to support wider societal and economic goals. Through their procurement, supply chains and role as an employer, they have significant influence over social and economic development in their communities. NHS employment is to become a force for economic prosperity and social mobility.

3.2.8. The Plan also prioritises the NHS' existing commitments set out in Delivering a Net Zero Health Service - including achieving net zero by 2040 for the emissions the NHS controls and by 2045 for the emissions it can influence.

3.2.9. The plan acknowledges the link between employment and mental health, aiming to support individuals in finding and maintaining employment through various initiatives and we can build on our existing Talking Therapies and Individual Placement Support services that are already being commissioned. We can also ensure that all Talking Therapies services provide self-referral access through the My Specialist tool.

3.3. **What we need to work on next?**

3.3.1. The first element of focus in the National Plan is Screening and Immunisations. People from our most deprived communities are less likely to take up a vaccination and/ or screening offer although the burden of disease/ infection they afford protection from/ early detection of can sometimes affect these communities the most. Our work has seen new successful innovations introduced to tackle these challenges by – Improving uptake through outreach models via the Living Well Bus, CIPHA Case Finding and Healthcare worker insight research.

3.3.2. Currently screening and immunisation services are commissioned by NHSE, and the intention is for these to be transferred over to the ICB was for April 2026. Given the significant changs to the NHS Operating Model, it is possible that the transfer of these services is delayed further. A Screening and Immunisation Oversight Group has been established during the last year and is overseeing the development of a future model to help enhance the uptake of crucial preventative health services for our residents. The Ten-Year Plan is explicit in stating we should do far better at taking the immediate opportunities available to deliver prevention: vaccination, screening and early diagnosis.

3.3.3. Reducing the prevalence of modifiable risk factors - as part of the NHS' prevention responsibility, we would like to get to a place where all NHS staff are assessing, recording, advising and referring patients across the four modifiable risk factors of smoking, diet, alcohol and physical activity.

3.3.4. A second element is establishing the New Genomics Population Health Service. The Ten-Year Health Plan is looking to the longer-term and will create a new genomics population health service, to harness the potential for predictive analytics to support more predictive and precise prevention in the future. This would be a significant area of growth for our ICB and understanding how we would interface with a new national programme in this area. However, we are one of the leading ICB areas with a Familial Hypercholesterolemia Service FH now in place. This is an important genetic condition affecting approximately 1 in 250 people and can lead to high levels of LDL-C and premature CVD, yet it remains underdiagnosed and undertreated across the UK. The Ten-Year Plan will expand services like these and genomic testing for inherited causes of major diseases to allow earlier detection and intervention, including cancer (e.g. BRCA1/2 genes), and cardiovascular disease predisposition

3.3.5. The third element of the National Plan to help shift from sickness to prevention, is for the NHS to be incentivised to move away from more hospital activity towards population health outcomes. Our ICB needs to develop its approach to health economics and value-based commissioning, with population health budgets that commit on medium term delivery, rather than year on year planning cycles. We have seen this current approach hinder the positive impacts to be gained on reducing health and care demand and improving health outcomes for our residents.

3.3.6. The Plan includes a commitment to shift resource towards community and neighbourhood health services. From financial year 2026 to 2027, the NHS locally will move closer to its fair share of funding, based on health need. The Advisory Committee on Resource Allocation (ACRA) will independently review the findings of the Chief Medical Officer's recent reports on health across different communities and in an ageing society to inform allocation of resources to and by ICBs in 2027 to 2028. Extra funding will be targeted to areas with disproportionate economic and health challenges and the Carr-Hill formula for general practice will also be reviewed.

3.3.7. As the Children's Wellbeing and Schools Bill legislation comes into place we will look to health practitioners being included in the child protection teams.

3.3.8. Roll out Staff Treatment Hubs, a high-quality occupational health service for all NHS staff that includes support for back conditions and mental health issues, both significant causes of long-term sickness absence.

Key References

10 Year Health Plan for England: fit for the future
https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

Carnall Farrar Summary
https://www.carnallfarrar.com/fit-for-the-future-the-nhs-10-year-health-plan-for-england/

NHS Confederation
https://www.nhsconfed.org/publications/ten-year-health-plan-what-you-need-know

The Kings Fund
https://www.kingsfund.org.uk/insight-and-analysis/press-releases/specific-topics-10-year-plan-for-health

Local Government Association
https://www.local.gov.uk/parliament/briefings-and-responses/fit-future-10-year-health-plan-england

Department of Health & Social Care

Karin Smyth MP
Minister of State for Health (Secondary Care)

39 Victoria Street
London
SW1H 0EU

ICP Chairs and Co-Chairs

Sent via email

03 July 2025

Dear all,

Today marks a significant moment in the history of our NHS, as the government publishes its 10 Year Health Plan. The Plan sets out how we will help the NHS recover, deliver seismic changes in its operation to make it fit the future, and transform the country's health for generations to come. I know many of you will have played a significant role in the Plan's development, drawing on your expertise and experience to share ideas for delivering the change required. I extend my thanks to you all.

As you know, integrated care partnerships (ICPs) were created by the Health and Care Act 2022, with the purpose of bringing together system partners concerned with the care, health, and wellbeing of the local population. The current broad membership of ICPs reflects the ambition of system partners to work together to improve the health and wellbeing of their residents, and the important role that you as chairs and co-chairs have played as system convenors.

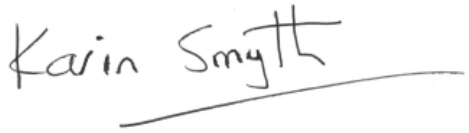
I extend my thanks to you and your members for fulfilling the core statutory duty of ICPs and developing integrated care strategies, setting the overall strategic direction for your systems and detailing how the local population's health needs are to be met by your integrated care board (ICB) and its partner local authorities. Despite the significant pace at which these strategies were first produced, they were developed in close collaboration with local partners and stakeholders and reflected real ambition to improve population health and wellbeing. These strategies often transcended a focus on frontline health services, to include consideration of the wider determinants of health and broader socioeconomic development conducive to improving the local population's health and wellbeing. Local residents are at the heart of every integrated care strategy which seek to encourage system partners to work in new and radical ways, drawing on what is already working well, and hold each other to account for progress.

ICPs are however currently operating in a confusing landscape, amidst a plethora of plans, strategies and committees. This means despite your hard work and dedication, and that of the members of your ICPs, there is too often confusion leading to frustration, siloed working, and inaction. We wish to harness the enthusiasm and creativity you and your colleagues have brought to ICPs in a more effective way that removes the inhibitors you have encountered. Therefore, the 10 Year Health Plan sets out our proposals for a simplified landscape, with greater clarity on roles, functions and accountabilities. In this new landscape, ICPs will no longer be a statutory requirement and therefore abolished. As we remove the statutory prescription, we are keen that the learning, energy,

partnership and leadership that many of you have sought to bring to ICPs continues to play a strong role in supporting partnership working, particularly in the development of neighbourhood health and in supporting ICBs to become effective strategic commissioners. The abolition of ICPs is not intended to diminish partnership arrangements between the NHS, local government and wider system partners. Instead, it is intended to allow these partnerships to flourish in more impactful ways. Our 10 Year Plan sets out the importance of partnership working, particularly in the development of neighbourhood health plans, and I am thankful for the enthusiasm and energy I know you and your colleagues will bring to this endeavour.

I reiterate my thanks to you all for your helping to shape our 10 Year Plan, and for the commitment you and your colleagues have shown to date. As we move forward now towards implementing our Plan, I trust your skill, commitment and experience will ensure our success and in achieving our goal of better health for all.

Kind regards,



KARIN SMYTH MP
MINISTER OF STATE FOR HEALTH

Cheshire and Warrington Councils request that Mayoral election takes place in May 2027

Cheshire East Council, Cheshire West and Chester Council, and Warrington Borough Council have requested that the area's potential Mayoral election, planned for May 2026, is deferred by a year.

The three partner councils have written to the Government to request that the election is now held in May 2027, a year later than planned, and in line with local elections taking place across Cheshire East and Cheshire West and Chester.

Cllr Louise Gittins, Leader of Cheshire West and Chester Council, Leader and Deputy Leader of Cheshire East Council, Cllr Nick Mannion and Cllr Michael Gorman, and Cllr Hans Mundry, Leader of Warrington Borough Council, said:

"Moving the election would give us more time to put in place the right foundations and approach to move forward with a devolution agreement with an elected Mayor.

"We are committed to making devolution happen for Cheshire and Warrington and, from initial conversations we've had with our communities and stakeholders, people are generally supportive of our plans and the benefits devolution will bring to our area.

"A devolution agreement for Cheshire and Warrington would mean additional powers and funding being drawn down from government – bringing more jobs, better transport and smarter investment to the area. It means more decisions about the things that really matter to people are made closer to home by people who know the area best, and significant long-term funding that is in local control.

"While we have always maintained that we want to release the potential benefits of devolution as early as possible, we have heard what people have said and recognise that by holding the Mayoral election in May 2027 – at the same time as a number of local elections taking place across the area – we can reduce costs and potentially increase the number of people who will turn out to vote and have their voice heard.

"Establishing a Mayoral Combined Authority is subject to the outcome of the government's statutory tests. It is also subject to formal decisions across the three councils, which are expected in September 2025.

"We will continue our work in the meantime to progress establishing a Mayoral Combined Authority for Cheshire and Warrington in early 2026, subject to the councils' approval. This would still give our area more funding and more powers and be a positive step on our journey to electing a Mayor in May 2027."

This follows the announcement in February this year that Cheshire and Warrington was included in the government's Devolution Priority Programme (DPP), alongside five other

areas across the country, following the three councils expressing their interest to government.

The DPP is fast-track programme as part of the government's intention to extend devolution across England, giving regions more powers and funding in areas such as transport and infrastructure, planning and housing, economic development, and skills and employment support.

Further information about devolution for Cheshire and Warrington can be viewed at cheshireandwarringtondevolution.com.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

Cheshire and Merseyside Integrated Care System Finance Report Month 2 (2025/26)

Agenda Item No: ICB/07/25/06

Responsible Director: Mark Bakewell, Executive Director of Finance (Interim)

Cheshire and Merseyside
System Finance Report Month 2 (2025/26)

1. Purpose of the Report

1.1 Regular financial performance reports are provided to the Finance, Investment and Resources Committee (FIRC) of the ICB who undertake detailed review and challenge on behalf of the Board.

1.2 This report provides an update to the Board on the financial performance of the Cheshire and Merseyside ICS ("the ICS") at Month 2 2025/26, in terms of relative position against its financial plan, and alongside other measures of financial and operational performance (e.g. efficiency, productivity and workforce).

1.3 The Board is asked to note the contents of this report in respect of the May-25 ICS financial position for both revenue and capital allocations.

2. Executive Summary

2.1 On 27th March 2025 the System 'ICS' plan submitted was a combined £255m deficit, consisting of £23.6m surplus on the commissioning side (ICB) partially offsetting an aggregate NHS Provider deficit position of £278.7m. This plan was not approved by NHS England (NHSE), and subsequently a revised plan of £178.3m deficit (£50.4m surplus for the ICB and £228.6m for providers) was agreed and submitted on 30th April 2025. The detailed movements and key planning assumptions had been set out in a separate 2024/25 planning update paper reported to FIRC.

2.2 As part of submitting a £178.3m deficit plan the ICS has been allocated £178.3m deficit support funding from NHSE to cover the deficit and allow the financial system plan to be adjusted to a balanced breakeven position. The funding has been allocated to providers via an agreed system methodology and in turn collective provider plans have improved. As per current NHS business rules the revenue deficit support is deemed repayable to NHSE. The deficit support funding will only be released to the system quarterly subject to prospective assurance from NHSE covering areas such as progress with delivery of efficiency plans, and review of expenditure and workforce run rates.

2.3 As of 31 May 2025 (Month 2), the ICS system is reporting a YTD deficit of £67.1m against a planned YTD deficit of £67.3m resulting in a favourable YTD variance of £0.2m (excluding the deficit support funding). The system financial position as reported to NHSE at Month 2 is set out in **Table 1** below.

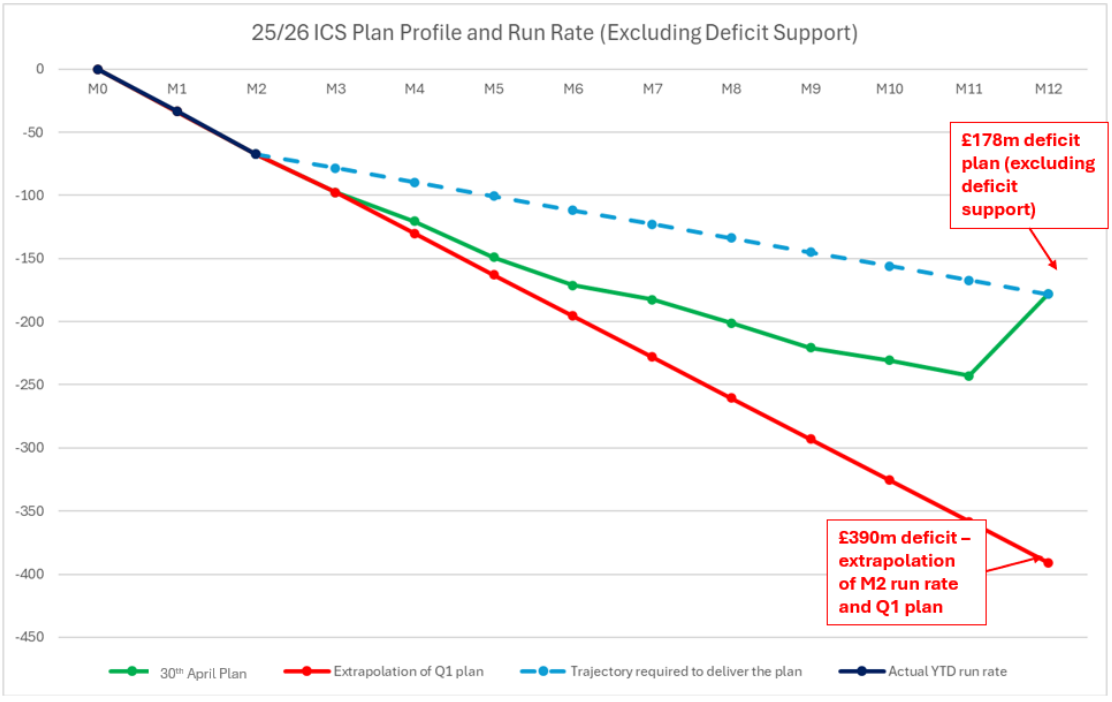
Table 1 – Financial Performance Month 2 - ICS

	Month 2 YTD				FY FOT
	Plan £m	Actual £	Variance £	%	£m
ICB	8.4	8.4	(0.0)	(0.0)	50.4
Total Providers	(46.0)	(45.8)	0.2	0.0	(50.3)
Total System	**(37.6)**	**(37.4)**	**0.2**	**0.0**	**0.0**
Total Providers (excluding £178m deficit support)	(75.7)	(75.5)	0.2	0.0	(228.6)
Total System (excluding £178m deficit support)	**(67.3)**	**(67.1)**	**0.2**	**0.0**	**(178.3)**

2.4 **Chart 1** below shows the profile of the ICS I&E plan submitted to NHSE on 30th April against the actual M2 YTD run rate (excluding deficit support funding). It also shows the monthly run rate trajectory required to support delivery of the plan.

2.5 It should be noted that at £67.1m YTD deficit, the system has incurred 38% of its £178.3m deficit plan in the first 2 months of the year. This reflects the challenging profile of the plan where CIPs and system recovery plans have been assumed to deliver towards the end of the year. The current run rate will need to improve significantly in order for the system plan to be achieved and so focus and acceleration of CIP and system recovery plans will be critical over the next few weeks.

Chart 1 – ICS Financial Performance – YTD Run Rate vs Plan Profile



2.6 The summary of the key M2 I&E (excluding deficit support) and CIP metrics against plan by organisation is set out in **Table 2**

Table 2 – Financial Performance Month 2 – by organisation

Org	Month 2 YTD			FY FOT			CIP YTD			
	YTD Plan	YTD Actual	YTD Variance	FY Plan	FOT	Variance	YTD Actual	Variance to YTD Plan	YTD Actual CIP as a % of Op Expend	M2 CIP Recurrent as a % of YTD plan
	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	%	%
Alder Hey Children's	(1,903)	(1,903)	0	7,160	7,160	(0)	1,608	(1,191)	2.2%	26%
Bridgewater Community	(894)	(883)	11	(1,530)	(1,530)	0	760	0	4.2%	100%
Cheshire & Wirral Partnership	(1,340)	(1,340)	0	3,985	3,985	0	836	(1,139)	1.6%	37%
Countess of Chester Hospitals	(8,742)	(8,742)	0	(34,042)	(34,042)	0	726	(1,306)	1.0%	36%
East Cheshire Trust	(4,722)	(4,720)	2	(17,934)	(17,934)	0	1,686	(0)	4.1%	42%
Liverpool Heart & Chest	1,139	1,093	(46)	9,552	9,552	0	849	(798)	2.0%	22%
Liverpool University Hospitals	(15,573)	(15,483)	90	(56,609)	(56,609)	0	18,931	5,360	7.8%	95%
Liverpool Women's	(5,786)	(5,770)	16	(31,026)	(31,026)	0	1,312	(38)	4.0%	53%
Mersey Care	158	158	0	14,305	14,305	0	4,989	(633)	3.8%	61%
Mid Cheshire Hospitals	(8,790)	(8,751)	39	(39,380)	(39,380)	0	3,423	(574)	4.3%	44%
Mersey & West Lancs	(16,453)	(16,443)	10	(40,950)	(40,950)	(0)	7,368	0	4.3%	35%
The Clatterbridge Centre	45	49	3	890	890	0	858	(1,190)	1.5%	27%
The Walton Centre	830	833	3	6,900	6,900	(0)	1,742	0	5.0%	89%
Warrington & Halton Hospitals	(9,297)	(9,287)	10	(28,726)	(28,725)	0	1,676	0	2.4%	59%
Wirral Community	(327)	(317)	10	900	900	0	713	12	3.9%	102%
Wirral University Hospitals	(4,046)	(4,013)	33	(22,140)	(22,140)	(0)	5,336	(1)	5.9%	49%
TOTAL Providers	**(75,701)**	**(75,520)**	**181**	**(228,643)**	**(228,643)**	**(0)**	**52,813**	**(1,497)**		**59%**
C&M ICB	8,395	8,392	(3)	50,367	50,367	0	8,228	(388)	5.3%	95%
TOTAL ICS System	**(67,306)**	**(67,128)**	**178**	**(178,276)**	**(178,276)**	**(0)**	**61,041**	**(1,885)**	**4.4%**	**64%**

2.7 Whilst the system is on plan at Month 2 the key issues prevalent in the Month 2 financial position are:

- The system has incurred 38% of its £178.3m deficit plan in the first 2 months of the year
- A £1.9m CIP shortfall against the planned YTD efficiencies of £63m, of which only 64% have been delivered recurrently (£39m).
- Paragraph 33 sets out the maturity status of collective system CIP plans – as at Month 2 £104m (18%) of efficiencies are at opportunity stage and a further £10m (2%) unidentified) and is a key risk to delivery of plan.
- In additional there is c£155m of full year system recovery schemes of varying levels of development that sit outside of organisational CIP plans that require implementation to support financial plan delivery. See paragraphs 34-40 for further details on progress to date.
- Providers' pay expenditure is above YTD pay plan (£8.3m, 1%), particularly across bank expenditure which is above both plan and the NHSE bank ceiling set as part of planning.
- Provider levels of cash are diminishing, with a minimum of four organisations expecting to apply to NHSE for external cash support from M5 onwards.

Financial Performance Month 2

ICS financial performance – M2

2.8 As of 31 May 2024 (Month 2), the ICS is reporting a YTD deficit (excluding deficit funding support) of £67.1m against a planned YTD deficit of £67.3m resulting in a favourable YTD variance of £0.2m. The YTD deficit of £67.3m represents 38% of the full year plan of £178.3m deficit.

2.9 **Table 3** sets out the financial performance surplus / (deficit) at Month 2 at organisation level.

Table 3 – ICS Financial Performance M2 YTD by organisation

Org	Month 2 YTD				Full Year	
	YTD Plan	YTD Actual	YTD Variance	YTD a s % of YTD Income	FOT	Mth 2 YTD as a % of FOT
	£,000	£,000	£,000	%	£,000	%
Alder Hey Children's	(1,903)	(1,903)	0	-3%	7,160	-27%
Bridgewater Community	(894)	(883)	11	-5%	(1,530)	58%
Cheshire & Wirral Partnership	(1,340)	(1,340)	0	-3%	3,985	-34%
Countess of Chester Hospitals	(8,742)	(8,742)	0	-14%	(34,042)	26%
East Cheshire Trust	(4,722)	(4,720)	2	-13%	(17,934)	26%
Liverpool Heart & Chest	1,139	1,093	(46)	3%	9,552	11%
Liverpool University Hospitals	(15,573)	(15,483)	90	-7%	(56,609)	27%
Liverpool Women's	(5,786)	(5,770)	16	-20%	(31,026)	19%
Mersey Care	158	158	0	0%	14,305	1%
Mid Cheshire Hospitals	(8,790)	(8,751)	39	-12%	(39,380)	22%
Mersey & West Lancs	(16,453)	(16,443)	10	-10%	(40,950)	40%
The Clatterbridge Centre	45	49	3	0%	890	5%
The Walton Centre	830	833	3	2%	6,900	12%
Warrington & Halton Hospitals	(9,297)	(9,287)	10	-15%	(28,725)	32%
Wirral Community	(327)	(317)	10	-2%	900	-35%
Wirral University Hospitals	(4,046)	(4,013)	33	-5%	(22,140)	18%
TOTAL Providers	**(75,701)**	**(75,520)**	**181**	**-7%**	**(228,643)**	**33%**
C&M ICB	8,395	8,392	(3)		50,367	17%
TOTAL ICS System	**(67,306)**	**(67,128)**	**178**		**(178,276)**	**38%**

ICB Financial Performance – M2

2.10 The ICB reports a surplus of £8.4m for month 2 which is in line with the YTD plan as per **Table 4** below.

Table 4 – ICB Financial Performance M2

	M2 YTD			
	Plan £m	Actual £m	Variance £m	Variance %
ICB Net Expenditure				
Acute Services	**631.0**	**631.3**	**(0.3)**	**(0.0%)**
Acute services - NHS	611.6	610.2	1.5	0.2%
Acute services - Independent/commercial sector	19.8	20.0	(0.2)	(0.9%)
Acute services - Other non-NHS	1.2	1.3	(0.1)	(7.5%)
Acute Services - Other Net Expenditure	(1.7)	(0.2)	(1.5)	88.7%
Mental Health Services	**130.3**	**130.9**	**(0.6)**	**(0.5%)**
MH Services - NHS	85.0	84.9	0.1	0.1%
MH Services - Independent / Commercial Sector	29.8	28.5	1.3	4.4%
MH Services - Other non-NHS	16.4	17.0	(0.5)	(3.2%)
MH Services - Other net expenditure	(1.0)	0.5	(1.5)	149.6%
Community Health Services	**119.9**	**119.9**	**(0.0)**	**(0.0%)**
Continuing Care Services	**82.7**	**83.2**	**(0.5)**	**(0.6%)**
Primary Care Services	**108.0**	**108.5**	**(0.6)**	**(0.5%)**
Memo: Prescribing *	88.5	88.6	(0.1)	(0.1%)
Other Commissioned Services	**2.6**	**2.5**	**0.1**	**3.3%**
Other Programme Services	**9.5**	**9.8**	**(0.2)**	**(2.5%)**
Reserves / Contingencies	**0.8**	**0.0**	**0.8**	**100.0%**
Delegated Specialised Commissioning	**123.6**	**123.6**	**(0.0)**	**(0.0%)**
Delegated Primary Care Commissioning	**152.8**	**151.5**	**1.4**	**0.9%**
Primary Medical Services	101.5	100.4	1.1	1.1%
Dental Services	34.7	34.5	0.2	0.7%
Ophthalmic Services	4.8	4.8	0.0	0.0%
Pharmacy Services	11.7	11.7	0.0	0.0%
ICB Running Costs	**6.9**	**6.9**	**(0.0)**	**(0.0%)**
Total ICB Net Expenditure	**1,367.9**	**1,367.9**	**(0.0)**	**(0.0%)**
TOTAL ICB Surplus/(Deficit)	**8.4**	**8.4**	**(0.0)**	**(0.0%)**

* classification of prescribing costs differs slightly from the values reported to NHSE through the IFR

2.11 As the quarterly receipt of the system deficit support funding is dependent on the system maintaining a year-to-date position in line with plan, the focus of the analysis will be on the YTD position at this early stage. The key areas of variance from budget are as follows:

a) Acute performance – Pressure across most places on Independent Sector Ophthalmology activity. Ophthalmology contracts have overperformed by £0.6m during the first two months of the year, however this is partially offset by £0.4m of underperformance across other independent sector acute providers.

b) Mental Health Contracts – Mental health budgets reported in the table above include both mental health contracts and mental health packages of care. There is a developing pressure in relation to ADHD services which is reported to be overspending by £1.1m as at month 2. This is partially offset by a £0.4m underspend on individual mental health packages of care.

c) All Age Continuing Care – Reporting a year to date adverse variance of £0.5m at month 2. The pressure is in relation to CHC Fully funded cases and Funded Nursing care budgets. **Appendix 1** contains additional information to support the CHC and MH packages of care budgetary performance. Place reporting packs have been developed providing both financial and activity information including high cost packages and run rates and further detail will be included in the finance report for month 3.

d) Primary Care – Local primary care services budgets appear to show a pressure of £0.6m. This range of budgets covers all local core primary care and prescribing costs but excludes Delegated Primary Care Commissioning.

The £0.6m shortfall it relates to costs within the local incentive scheme budget that had previously been included in Delegated GP budgets. However, due to the restrictions applied to the allocations, it is not possible to transfer the budget to match the expenditure. Primary Care budgets in total are reporting a year-to-date underspend at this early stage in the year.

e) Prescribing – At the time of preparing the month 2 financial position, the ICB was not in receipt of any prescribing data relating to the new financial year. Future reports will include more detailed analysis of the cost per prescribing day over the course of the financial year and performance against medicines management efficiency savings plans.

f) Reserves – A year-to date surplus of £0.8m is reported on reserves. This relates in the main to slippage on primary care investments and uncommitted inflation reserves from 24/25.

g) Running costs – The ICB reports in line with running cost budgets at month 2. The ICB's allocation was reduced by £3.5m in 2025/26 as part of the original target of a 30% reduction in running costs. A further CRES target of £0.4m was required for 2025/26 to offset the impact of pay awards.

h) Efficiency – The ICB reports slippage of £388k against the YTD efficiency plan of £8,616k. The main areas of slippage reported are within mental health out of area placements and prescribing. Overachievement of efficiency savings within all age continuing care has partially offset the negative impact.

Provider Financial Performance – M2

2.12 **Table 3 above** sets out the ICS Month 2 financial position, split by individual provider alongside ICB position.

2.13 Whilst providers are on plan at M2 there are several areas covering CIP, expenditure run rates, WTE run rates, variable pay, and capital and cash will be subject to review and challenge over the next few weeks. The sections below set out the current position and key indicators across these areas.

2.14 **Table 6** sets out the provider YTD position by income, pay and non-pay. This indicates that the aggregate YTD pay position is £8.2m (1%) adverse to plan. The majority of this relates to unachieved pay efficiencies £3.6m (0.4%) with a reminder a number of operational issues requiring further review with providers. Provider income is £7m ahead of plan (0.6%) and the triangulation of any ICB and specialised commissioning contractual income against API contracts will be a key line of enquiry over June. It is expected that pass through drugs and devices will make up a material amount of this variance.

Table 6 – Provider Income and Expenditure vs YTD Plan

	Income - YTD			Total Pay - YTD			Non Pay - YTD			Income YTD Variance	Pay YTD Variance	Non Pay YTD Variance
	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance			
	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	%	%	%
Alder Hey Children's	71,434	71,112	(323)	(47,000)	(47,412)	(412)	(25,366)	(24,594)	773	-0.5%	-0.9%	3.1%
Bridgewater Community	16,564	16,409	(155)	(12,284)	(12,366)	(82)	(5,109)	(4,861)	247	-0.9%	-0.7%	5.1%
Cheshire & Wirral Partnership	47,026	49,073	2,047	(39,177)	(40,565)	(1,388)	(9,020)	(9,686)	(666)	4.4%	-3.4%	-6.9%
Countess of Chester Hospitals	63,178	64,047	868	(48,901)	(48,605)	296	(19,102)	(20,504)	(1,402)	1.4%	0.6%	-6.8%
East Cheshire Trust	36,452	36,842	390	(26,643)	(26,889)	(246)	(12,533)	(12,731)	(198)	1.1%	-0.9%	-1.6%
Liverpool Heart & Chest	42,836	42,911	75	(21,160)	(21,262)	(102)	(20,320)	(20,435)	(115)	0.2%	-0.5%	-0.6%
Liverpool University Hospitals	216,660	219,796	3,136	(149,288)	(153,194)	(3,906)	(72,356)	(71,793)	563	1.4%	-2.5%	0.8%
Liverpool Women's	28,693	28,808	115	(19,852)	(20,180)	(328)	(11,802)	(11,621)	181	0.4%	-1.6%	1.6%
Mersey Care	126,712	127,826	1,114	(100,518)	(102,131)	(1,613)	(25,180)	(24,813)	367	0.9%	-1.6%	1.5%
Mid Cheshire Hospitals	72,306	71,623	(683)	(52,392)	(52,995)	(603)	(23,981)	(22,710)	1,271	-0.9%	-1.1%	5.6%
Mersey & West Lancs	158,355	156,699	(1,656)	(109,033)	(110,962)	(1,929)	(54,864)	(51,396)	3,468	-1.0%	-1.7%	6.7%
The Clatterbridge Centre	51,685	56,101	4,416	(19,696)	(20,342)	(646)	(31,501)	(35,652)	(4,151)	8.5%	-3.2%	-11.6%
The Walton Centre	33,535	33,618	83	(17,222)	(17,584)	(362)	(15,520)	(15,246)	274	0.2%	-2.1%	1.8%
Warrington & Halton Hospitals	63,572	62,564	(1,009)	(49,600)	(49,053)	547	(19,362)	(19,065)	297	-1.6%	1.1%	1.6%
Wirral Community	17,694	17,440	(254)	(13,933)	(13,402)	531	(3,952)	(4,223)	(271)	-1.4%	4.0%	-6.4%
Wirral University Hospitals	85,822	84,680	(1,142)	(61,973)	(60,005)	1,968	(24,267)	(25,198)	(931)	-1.3%	3.3%	-3.7%
TOTAL Providers	**1,132,526**	**1,139,548**	**7,022**	**(788,672)**	**(796,947)**	**(8,275)**	**(374,235)**	**(374,528)**	**(293)**	**0.6%**	**-1.0%**	**-0.1%**

2.15 **Table 7** sets out spilt of provider pay expenditure across substantive, bank and agency. This indicates that the aggregate YTD pay position is £8.2m (1%) adverse to plan, with bank expenditure the material outlier at £5.3m over plan. As part of the planning process providers set bank and agency plans in line with NHSE expectations of a reduction bank expenditure by 10% and agency expenditure by 30% compared to 24/25 run rates. Section 9 of the report sets out the bank and agency position in more detail.

Table 7 – Provider Pay spilt by substantive, bank and agency vs plan

	TOTAL PAY EXPENDITURE (SUB,			TOTAL SUBSTANTIVE			TOTAL BANK			TOTAL AGENCY		
	M2 YTD Actual £,000	M2 YTD Variance £,000	M2 YTD Variance %	M2 YTD Actual £,000	M2 YTD Variance £,000	M2 YTD Variance %	M2 YTD Actual £,000	M2 YTD Variance £,000	M2 YTD Variance %	M2 YTD Actual £,000	M2 YTD Variance £,000	M2 YTD Variance %
Alder Hey Children's	(47,412)	(412)	-0.9%	(46,386)	(639)	-1.4%	(900)	50	5%	(113)	45	28%
Bridgewater Community	(12,366)	(82)	-0.7%	(12,071)	(207)	-1.7%	(223)	(23)	-12%	(72)	149	67%
Cheshire & Wirral Partnership	(40,565)	(1,388)	-3.4%	(37,883)	(1,619)	-4.5%	(1,634)	(203)	-14%	(895)	431	33%
Countess of Chester Hospitals	(48,605)	296	0.6%	(44,728)	501	1.1%	(3,189)	(339)	-12%	(501)	129	20%
East Cheshire Trust	(26,889)	(246)	-0.9%	(23,769)	(760)	-3.3%	(2,511)	77	3%	(609)	407	40%
Liverpool Heart & Chest	(21,262)	(102)	-0.5%	(20,606)	(58)	-0.3%	(517)	17	3%	(50)	28	36%
Liverpool University Hospitals	(153,194)	(3,906)	-2.5%	(141,414)	(1,978)	-1.4%	(9,648)	(1,606)	-20%	(1,547)	(461)	-42%
Liverpool Women's	(20,180)	(328)	-1.6%	(18,922)	44	0.2%	(928)	(179)	-24%	(255)	(191)	-296%
Mersey Care	(102,131)	(1,613)	-1.6%	(92,185)	423	0.5%	(7,993)	(1,883)	-31%	(1,953)	(153)	9%
Mid Cheshire Hospitals	(52,995)	(603)	-1.1%	(48,387)	(339)	-0.7%	(3,002)	(196)	-7%	(1,388)	(82)	-6%
Mersey & West Lancs	(110,962)	(1,929)	-1.7%	(100,490)	(1,025)	-1.0%	(7,592)	(274)	-4%	(2,477)	(622)	-34%
The Clatterbridge Centre	(20,342)	(646)	-3.2%	(19,868)	(548)	-2.8%	(231)	(65)	-39%	(208)	2	1%
The Walton Centre	(17,584)	(362)	-2.1%	(16,891)	(432)	-2.6%	(659)	104	14%	(34)	(34)	-100%
Warrington & Halton Hospitals	(49,053)	547	1.1%	(43,787)	665	1.5%	(4,828)	(164)	-4%	(438)	46	-10%
Wirral Community	(13,402)	531	4.0%	(12,698)	631	4.7%	(623)	(118)	-23%	(81)	18	-18%
Wirral University Hospitals	(60,005)	1,968	3.3%	(54,155)	2,569	4.5%	(4,373)	(518)	-13%	(1,247)	(71)	6%
TOTAL	**(796,947)**	**(8,275)**	**-1.0%**	**(734,240)**	**(2,772)**		**(48,851)**	**(5,320)**		**(11,869)**	**(360)**	

NHS Provider Agency and Bank Expenditure

2.16 As part of the 2025/26 plan C&M ICS NHS Providers set a plan for agency spend of £66.7m, compared to the ICS agency ceiling set by NHSE for 2025/26 of £76.9m. Similarly, providers set a 2025/26 plan for bank spend of £259.9m, compared to the ICS bank ceiling set by NHSE for 2025/26 of £273.9m. This reflects the planning requirements to achieve a 30% reduction in agency expenditure and 10% reduction in bank expenditure compared to 2024/25 but also the additional efficiency requirements required to support overall plan delivery.

2.17 Agency spend is being closely monitored with approval required from NHS England for all non-clinical agency.

2.18 At Month 2, agency spend is £11.9m (£0.3m above plan), with seven providers reporting a YTD adverse variance to plan. Bank spend is £48.9m (£5.3m above plan, with 13 providers reporting a YTD variance to plan. Trust level information on agency and bank spend can be found in **Appendices 2 and 3**.

2.19 **Table 8** below sets out the aggregate agency and bank spend performance as a system. This indicates that bank expenditure is an area of concern, £5.3m over plan YTD and an extrapolation of the YTD position for the year could result in a significant overspend against plan and ceiling. Bank usage and reducing the rate price per shift has been a significant focus of the C&M financial control oversight group over June and progress is expected to the made in this area.

Table 8 – Provider Agency and Bank Expenditure

Agency Position	YTD Plan £m	YTD Actual £m	YTD Variance £m	FY Plan £m
All Providers Agency Spend	11.6	11.9	-0.3	66.7
C&M Annual Agency Ceiling				76.0
Forecast Variance to Ceiling				9.3
Extrapolation of M2 YTD				**71.2**

Bank Position	YTD Plan £m	YTD Actual £m	YTD Variance £m	FY Plan £m
All Providers Bank Spend	43.5	48.9	-5.3	259.0
C&M Annual Bank Ceiling				273.9
Forecast Variance to Ceiling				14.9
Extrapolation of M2 YTD				**293.1**

2.20 **Charts 3 and 4** below sets out the agency and bank expenditure monthly run rate from 24/25 Month 10 to 25/26 Month vs the position against plan and ceiling.

Chart 3 – Agency and Bank Expenditure Run Rate vs Plan and Ceiling

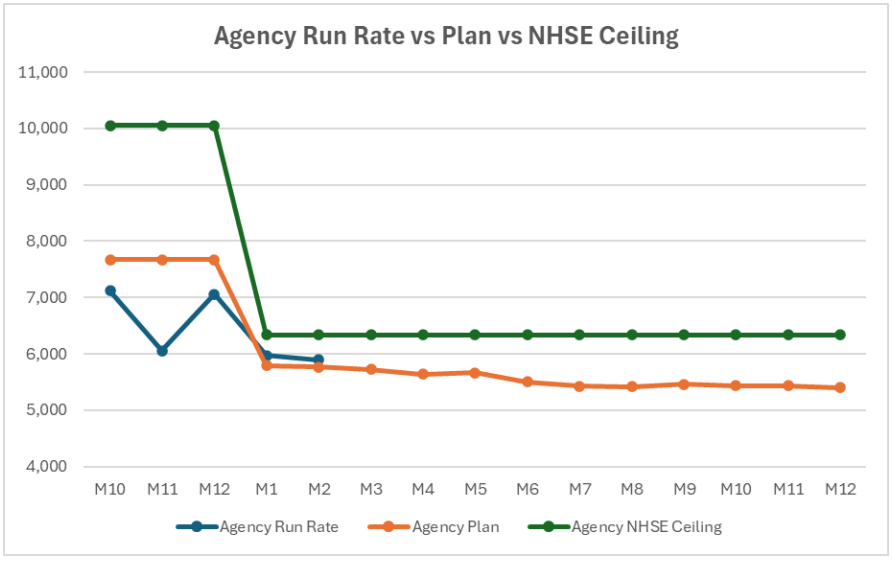
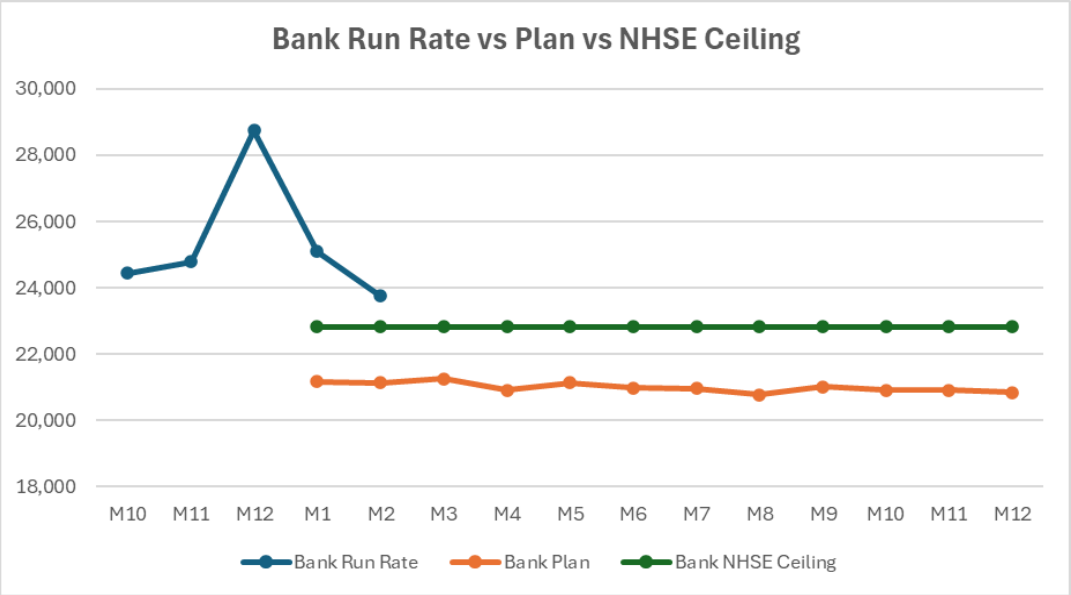


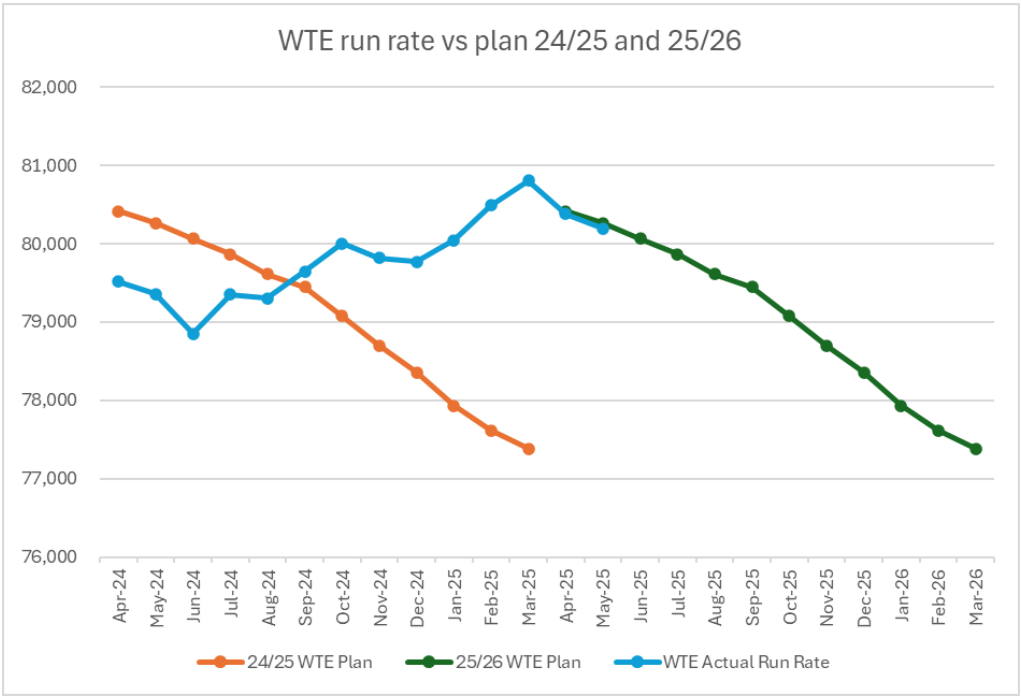
Chart 4 – Agency and Bank Expenditure Run Rate vs Plan and Ceiling



Workforce

2.21 Workforce and its triangulation with finance, performance and productivity will continue to be key focus across the system. **Chart 5** sets out the provider WTEs run rate across 24/25 to Month 2 25/26 and the planned aggregate planned reductions forecast to the end of the year. **Appendix 4** sets out in more detail the movements at provider level.

Chart 5 – Workforce (WTE) Run Rate 24/25 and 25/26



2.22 **Table 9** below sets out the workforce run rate per month and the actuals against M2 plan by sector:

Table 9 – M2 Workforce movements vs 24/25 run rate and M2 25/26 Plan

Workforce (WTEs) - source PWRs / mitigation plan submission	M10 Actuals	M11 Actuals	M12 Actuals	M1 Actuals	M2 Actuals	M10 to M2 Trend	M2 Plan	M2 Variance to Plan	% var to plan
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	%
C&M Providers Total	**80,046**	**80,492**	**80,808**	**80,381**	**80,194**		**80,265**	**70**	**0.1%**
by Sector									
Acute	49,731	49,918	50,108	49,814	49,756		50,055	299	0.6%
Specialist	11,645	11,768	11,821	11,641	11,626		11,778	152	1.3%
Community / MH	18,669	18,806	18,879	18,926	18,812		18,432	(380)	-2.1%
TOTAL Providers	**80,046**	**80,492**	**80,808**	**80,381**	**80,194**		**80,265**	**70**	**0.1%**

2.23 The Month 2 provider workforce data indicate there is a 70 WTE favourable position against the YTD plan (0.1%), however the WTE position is relatively static vs the run rate and higher than that of 6 months ago and 24/25 average. Triangulation of WTE run rates and pay expenditure run rates will be a key area of review and challenge with providers. At Month 2, whilst WTE is broadly in line with plan (0.1%), the pay expenditure is adverse to YTD plan by £8m. Triangulation of the workforce plans with finance and performance has been a critical key component of the 2025/26 planning process, and extended provider and system vacancy controls have been further strengthened in April 2025 including a recruitment freeze on non-clinical posts.

System Efficiencies

2.24 For 2025/26 providers and ICB are planning delivery of £433m and £139m efficiencies respectively. In addition to the aggregate system efficiency plan of £572m (7.1% of ICB Allocations), there is also £155m of ICB and provider system recovery schemes within providers plans but reported separately from the main CIP plans. These stretch system recovery schemes largely represent schemes across the urgent care pathway, non-criteria to reside, service changes that require system partner support to be developed and delivered

CIP position

2.25 **Table 10** shows at Month 2 there is currently a shortfall on planned CIP delivery of £1.9m against the ICS YTD plan, with £1.5m attributable against providers and £0.4m against the ICB. The £61.0m efficiencies delivered YTD represent 4.4% of provider and ICS expenditure/allocation against the annual plan of 7.1%, indicating a larger proportion of the savings required in the remaining months.

2.26 Furthermore only 64% of the system efficiencies YTD plan has been delivered recurrently as at Month 2. This increases the risk in the underlying financial position of the ICS and is subject to ongoing work by providers to both recover the YTD shortfall and address the recurrent position.

2.27 More detail on System efficiencies, by organisation, is included in **Appendix 6**.

Table 10 – ICS M2 YTD Efficiency Delivery

Org	CIP delivery (Month 2 YTD)					CIP Recurrent / Non Recurent YTD			Full year CIP	CIP Metrics	
	M2 YTD Plan	M2 YTD Actual	M2 YTD Variance	M2 YTD % Variance	M2 YTD CIP as a % of CIP FOT	M2 YTD Actual Recurrent	M2 YTD Actual Non Recurrent	M2 Actual Recurrent as a % of YTD plan	Full year CIP	M2 CIP delivery as a % of Op Ex	CIP FOT as % of Op Ex
	£,000	£,000	£,000	%	%	£,000	£,000	%	£,000	%	%
TOTAL Providers	**54,310**	**52,813**	**(1,497)**	**-3%**	**12%**	**31,808**	**21,005**	**59%**	**433,118**	**4.3%**	**7.0%**
C&M ICB	8,616	8,228	(388)	-5%	6%	8,228	-	95%	139,352	5.3%	7.5%
TOTAL ICS System	**62,926**	**61,041**	**(1,885)**	**-3%**	**11%**	**40,036**	**21,005**	**64%**	**572,470**	**4.4%**	**7.1%**

2.28 **Table 11** sets out the current risk and development status of efficiency schemes. As at the end of May 2024 20% of the CIP schemes are currently deemed to be at opportunity and unidentified stage. The maturity of CIP development is currently being reported to NHSE weekly and is a key metric in providing assurance on delivery of the overall plan. A Financial Control Oversight Group has been established since April, chaired by the System Turnaround Director, which brings both ICB Place teams and Providers Operational SROs together to progress schemes whilst along holding organisations to account. Further detail at organisational level on CIP maturity is included in **Appendix 6.**

Table 11 – Efficiency Development and Risk status (as at 31 May 2025)

	Fully Developed £,000	Plans in Progress £,000	Opportunity £,000	Unidentified £,000	Total Efficiencies £,000
Providers	269,356	75,791	77,643	9,792	**432,582**
ICB	84,389	32,852	26,344	-	**143,585**
C&M ICS	**353,745**	**108,643**	**103,987**	**9,792**	**576,167**
% of development status	**61%**	**19%**	**18%**	**2%**	

Additional System Recovery schemes position

2.29 As part of finalising the 2025/26 plans £222m of further system recovery and stretch opportunities were included in both ICB and provider plans. Due to nature of the opportunities a proportion of schemes (£67m) were included directly into organisation CIP plans, with the remaining £155m included within ICB and provider plans as cost reduction schemes but to be developed further and monitored outside of the CIP plans. **Table 12** below indicates the spilt of this between providers and the ICB

Table 12 – Stretch and system recovery schemes by organisation

	Scheme / Opportunity Area									
	UEC	Non-Criteria to Reside	Service Change	Provider Risk Share	Capital Opportunites	Interest Receivable from DSF	Stretch Schemes	TOTAL	*Included in org CIP Plan*	*Outside of CIP Plan*
	£m	£m	£m	£m	£m	£m	£m	£m	*£m*	*£m*
Alder Hey				1.2	2.3		3.8	**7.2**		*7.2*
Bridgewater			0.5	0.8	0.8		0.9	**2.9**		*2.9*
CCC				2.1	2.6		2.5	**7.2**	*2.5*	*4.7*
COCH	1.6	0.8		2.6	1.8	0.8	3.1	**10.7**	*5.0*	*5.7*
CWP				2.0	1.0		2.4	**5.4**		*5.4*
East Cheshire	0.6			1.5	1.3	0.4	1.8	**5.6**		*5.6*
Liv H&C				1.9	2.0		2.2	**6.1**	*2.2*	*3.9*
LUFT	6.0	6.6		9.2	9.4	1.5	10.9	**43.6**	*26.1*	*17.5*
LWH				1.2	1.9	0.5	1.4	**4.9**	*2.6*	*2.4*
Mersey Care					3.9		6.4	**10.3**		*10.3*
Mid Cheshire	2.1	1.7		3.0	2.1	0.8	3.5	**13.1**	*8.5*	*4.6*
MWL	8.4		8.0	6.8	3.7		8.0	**34.8**		*34.8*
Walton Centre				1.5	1.6		1.7	**4.8**	*1.7*	*3.1*
Warrington & Halton	2.0	0.8		3.0	2.8	1.0	3.5	**13.0**		*13.0*
Wirral Comm			0.2	0.8	0.8		0.9	**2.7**		*2.7*
Wirral Teaching	2.4	1.8		3.5	3.6	1.0	4.2	**16.5**	*2.4*	*14.1*
C&M ICB			6.3				27.0	**33.3**	*16.2*	*17.1*
Grand Total	**23.0**	**11.6**	**15.0**	**40.9**	**41.5**	**6.0**	**84.0**	**222.1**	***67.1***	***155.0***

2.30 Separate workstreams are being set up to identify areas of consistency potential opportunities for improvement and to replace ‘stretch’ items within planning assumptions.

2.31 They include reviews of arrangement for nursing and allied health professionals such review of overtime / bank rates, agreements for 1:1s and enhanced Care, and e-rostering arrangements. Also, would be movement towards a single contract with NHS professionals

2.32 For medical staff, similar reviews are taking place, again with specific lines of enquiry being Pay Enhancements, Waiting List initiatives, Standardised Rate cards ad Agency/locum spend

2.33 A separate urgent and emergency care meeting has been set up to review performance and opportunities for efficiency saving and to remove premium system costs for escalation areas.

2.34 Specific service changes have been identified within Bridgewater, Wirral Community and Mersey & West Lancashire Trust but further changes are being considered.

2.35 Trusts have identified £28.7m opportunity within the revenue to capital scheme. Further work is being undertaken to identify how to bridge the remaining gap by sharing approaches and looking for opportunities within grants. We are still awaiting confirmation from NHSE England as to whether the capital freedom opportunity is £41.5m as originally estimated.

Financial Recovery Approach and Turnaround

2.36 For 2025/26 a Financial Recovery and Oversight Group has been established to build on and follow on the work of Recovery undertaken during 2024/25 with a much tighter focus on financial efficiency.

2.37 The Financial Control and Oversight Group (FCOG) is responsible for the oversight and assurance of ICB and Provider efficiency programmes, through which the system will deliver its short and long-term financial plans. An update from FCOG is included as a separate agenda item.

2.38 The system received a letter from NHSE on the 19th May which advised that the system had been placed into formal turnaround due to the underlying deficit position and the level of financial risk for 2025/26.

2.39 PWC were commissioned by NHSE to perform a rapid three-week diagnostic of the system. This includes discussions with leaders across the system and build on relevant work undertaken to date in the system. The review will identify immediate recommendations to strengthen the financial plan for 2025/26 and will inform the scope of the turnaround which will follow.

2.40 In addition, Simon Worthington has been asked to undertake a review of the 2025/26 CIP forecast, reporting and delivery arrangements which will complement the work undertaken by PwC.

2.41 An initial report has been received by the system in early July with next steps and actions being considered by system leaders in conjunction with NHS England. Following the conclusion of this NHSE will advise of the scope of the subsequent turnaround, and of the formal regulatory intervention which will underpin it.

System Risks & Mitigations

2.42 Several risks have been reported through the recent planning progress and are subject to ongoing to monitoring and management by the respective organisations:

a. **Identification and delivery of recurrent CIPs** – this is subject to focussed System wide review to identify areas for acceleration and improvement.

b. **Provider contract performance against API contracts** – in 2025/26 the C&M ICB has a fixed level of resource for Elective Recovery and activity delivery whilst planning to deliver x% on RTT – this is subject to close monitoring through contract meetings.

c. **Inflation** – specifically; non-pay inflation for providers and prescribing and continuing care/packages of care for the ICB above national planning assumptions.

d. **Cost of out of area placements** arising from delayed transfers of care.

e. **Industrial action disruption** – the plan assumes no further industrial action throughout 25/26

f. **Deficit support funding** – plan assumes that providers receive funding quarterly but is dependent on plan delivery and NHSE assurance

The below information sets out further information as we currently understand the position for DSF for the remainder of the year.

Process for Q1

- For the first quarter, release of funding has been based upon the recently submitted plans and the work undertaken to assure that the plans are deliverable.
- We will also use any early intelligence from M1/2 reporting.

In summary this will include a focus on the following areas:

- De-risking the efficiency programme: including full identification of the plan by the end of Q1
- Workforce triangulation: understanding the drivers of the pay and efficiency differential and ensure that the workforce model is affordable.
- Delivery of bank reductions: Take actions to achieve the bank reduction in full including reduction in bank usage and reducing bank rates closer to substantive rates
- Review of cash requirements: Develop system cash management plan by the end of June 2025 to address any cash shortfalls at a local level wherever possible. Board visibility of cash position.

- Contract agreement: Providers and commissioners need to work together to agree contract envelopes and indicative activity plans in line with the expectations of the new NHS Payment Scheme.
- Underlying position: Update and refine assessments of underlying positions, ensuring Board visibility, focusing on recurrent measures that will strengthen financial positions into 2026/27 and beyond.

Process for the remainder of the year

- For the remainder of the year, NHSE's intention is to confirm funding at the start of each quarter and will use the most recent available data at the end of each quarter (so M2 data will be used in June to confirm Q2 allocations for the beginning of July, and so on).

- The assessment will confirm whether systems are on track to deliver plans. This will apply to a collective system position, rather than individual organisations, irrespective of whether a provider is assuming receipt of deficit support funding in plans. As a general rule, systems should be reporting that they are in line with plan year-to-date as well as forecasting plan delivery to be eligible for the release of funding. In exceptional cases, systems that have an adverse year to date position may still receive funding where there is a credible plan for delivery of the forecast out-turn.

- Where there have been delivery concerns and quarterly release of deficit support funding has not happened there will be the option of a catch-up payment where assurance is provided of plan delivery at a later date. Where quarterly funding has been issued and systems subsequently move to forecast a deficit there will not be a clawback, but future quarterly funding will be withheld.

- NHSE will use the regular monthly collections (PFR and IFR) to inform this assessment so organisations are being asked to ensure appropriate sign-off processes are in place within organisations to ensure that the returns are an accurate reflection of performance and will include a self-certification from CEO and Chair on behalf of the Board.

- In particular, the M8 YTD and FOT will be used to inform the release of Q4 funding. Where there is a movement in your FOT during Q4 you can expect this to attract additional scrutiny of your governance and control processes.

ADHD – growing cost due to expansion of IS providers in the market and higher prices.

Cash

2.43 The Providers' cash position at Month 2 was £414.5m, with the detail set out in **Appendix 7** by organisation. Year-end cash balances are £61.7m lower than at the end of 2024/25. The reduction is a combination of the YTD M2 deficit but

also payment of 24/25 capital creditors in the first two months. The average operating days cash in the system at Month 2 is 23 days but this ranges from 1 operating days cash in one provider to 99 days operating days cash in another. A cash working group has been established to share best practice on cash management strategies but also review all available options to providers and the ICB but to mitigate the need for further external cash support.

2.44 Acute organisations with a planned deficit have included in their cash forecasts receipt £178m deficit support funding. Release of this cash support is contingent on delivery of plans YTD and prospective quarterly assurance undertaken by NHSE on delivery of full year plans. There are five organisations that have included in their plans a requirement for external cash support from NHSE during 2025/26 to support their I&E deficit plans – Mersey and West Lancs Teaching NHS Trust, Warrington & Halton Teaching Hospitals FT, Liverpool Women's NHS FT, Countess of Chester Hospital NHS FT and Wirral Teaching Hospitals NHS FT.

2.45 **Table 13** below set out the aggregate provider cash balance at Month 2, the level of distress cash requests received from NHSE to date and forecast for the year, and the Month 2 average Better Payment Practice Code (BPPC) position across providers. The aggregate provider BPPC performance is currently at an average of 92.3% of number of bills paid within the 95%. Further detail of BPPC performance by provider is set put in **Appendix 8.**

Table 13 – Provider Cash and BPPC Performance – Month 2

Org	Cash Balance			Operating Days Cash	DHSC External Cash Support - Revenue		BPPC % of bills paid in target	
	2024/25 M12 Closing Cash Balance	2025/26 M2 Closing Cash Balance	Movement	25/26 M2 Actual	M2 YTD	FOT	2024/25 M2 By number	2024/25 M2 By Value
	£m	£m	£m	Days	£m	£m	%	%
Alder Hey Children's	53.7	38.1	(15.6)	35	0.0	0.0	92.4%	88.8%
Bridgewater Community	8.2	5.7	(2.5)	22	0.0	0.0	98.4%	98.9%
Cheshire & Wirral Partnership	28.5	24.0	(4.5)	31	0.0	0.0	98.3%	97.7%
Countess of Chester Hospitals	28.2	15.8	(12.4)	14	0.0	8.0	94.6%	94.3%
East Cheshire Trust	14.0	10.9	(3.1)	18	0.0	0.0	96.9%	97.0%
Liverpool Heart & Chest	49.4	48.1	(1.2)	76	0.0	0.0	98.0%	99.3%
Liverpool University Hospitals	30.4	30.2	(0.3)	8	0.0	0.0	74.4%	90.3%
Liverpool Women's	3.8	5.3	1.4	11	0.0	15.0	95.2%	97.1%
Mersey Care	53.8	49.4	(4.4)	24	0.0	0.0	95.4%	96.9%
Mid Cheshire Hospitals	36.3	35.0	(1.3)	30	0.0	0.0	95.4%	94.8%
Mersey & West Lancs	10.2	3.7	(6.5)	1	0.0	19.0	93.5%	95.5%
The Clatterbridge Centre	73.2	69.5	(3.6)	79	0.0	0.0	97.3%	99.1%
The Walton Centre	62.4	51.3	(11.2)	99	0.0	0.0	90.0%	96.1%
Warrington & Halton Hospitals	16.3	12.9	(3.4)	12	0.0	15.3	48.5%	48.8%
Wirral Community	7.8	10.5	2.7	39	0.0	0.0	90.4%	94.6%
Wirral University Hospitals	0.1	4.2	4.1	3	8.0	19.5	81.6%	91.0%
TOTAL Providers	**476.2**	**414.5**	**(61.7)**	**23**	**8.0**	**76.8**	**90.0%**	**92.5%**

2.46 The BPPC of WUTH and Warrington & Halton is of particular system concern. WUTH have been in conversations with the national team regarding their cash requirements and received £8m external cash support in Month 1.

2.47 The review of the cash position by national team has focussed on cash requests above planned deficit levels, workforce and financial recovery trajectories being on track and working capital balances i.e. high levels of receivables.

Provider and Primary Care Capital

2.48 The 'Charge against Capital Allocation' represents the System's performance against its operational core capital allocation, which is wholly managed at the System's discretion. For 2024/25 the System's Secondary Care Core allocation in 2023/24 is £200.0m, a Primary Care allocation of £6.0m, and an assumed allocation of £41.5m Capital Freedoms from prior year higher performing provider I&E surpluses and £2m UEC capital incentive allocation for high performing UEC performance in Q4 of 24/25. The Capital Freedoms and UEC Incentive capital remain subject to NHSE approval but have been included in the plan as per NHSE guidance. Within the overall £249m capital system plan £21.7m remains unallocated with the intention to allocate to providers once NHSE approvals have been confirmed on the capital freedoms and UEC incentive elements.

2.49 **Tables 14 & 15** sets out the Month 2 position capital expenditure against plan at a system level but also the ICB's primary care capital position. At Month 2 there is a YTD underspend of £20.7m which is across the provider sector.

Table 14 - System (Provider & ICB) - Charge against Capital Allocation M2

System (Provider & ICB) Charge against CDEL allocation	Plan YTD	Actual YTD	Variance YTD	Plan Year Ending	Forecast Year Ending	Variance Year Ending	
	£'000	£'000	£'000	£'000	£'000	£'000	%
System charge against allocation	44,285	23,530	20,755	249,501	249,501	0	0.0%
Capital allocation					249,501		
Variance to allocation					(0)		
Allocation met					Yes		

Table 15 – ICB - Charge against allocation M2

ICB Charge against CDEL allocation	Plan YTD	Actual YTD	Variance YTD	Plan Year Ending	Forecast Year Ending	Variance Year Ending	
	£'000	£'000	£'000	£'000	£'000	£'000	%
Cheshire And Merseyside ICB	-	-	-	27,712	27,713	(1)	(0.0%)
Capital allocation					27,713		
Variance to allocation					-		
Allocation met					Yes		

2.50 **Appendix 9** sets out the detailed M2 capital position by provider.

2.51 In addition to the core capital plans, the ICS has been allocated a further £64m of national funding across three main programme areas: Estates Safety, Constitutional Standards Recovery (covering Diagnostics, Elective and Urgent Care), Mental Health Out of Area Placements. The initial allocation of this was covered in the 25/26 planning paper but this spend remains subject to providers developing and submitting formal detailed business cases that require ICB letters of support and NHSE regional and national approval. A further update on the progress of these schemes will be provided in the Month 3 report.

3. Ask of the Board and Recommendations

3.1 The Board is asked to note the financial position and metrics reported at Month 2 and the risks to delivery of the financial plan which are described in the paper.

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Appendices

Appendix 1:	**Continuing Care and Complex Care Additional information M2**
Appendix 2:	**Agency Expenditure Run Rate – and position vs plan M1 and M2**
Appendix 3:	**Bank Expenditure Run Rate – and position vs plan M1 and M2**
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Appendix 9:	**Provider Capital Expenditure vs ICS Allocation at Month 2**

Appendix 1

Continuing Care and Complex Care Additional information M2

Financial performance by place

Mental Health Packages of Care	Year to Date		
	Budget (£000's)	Actual (£000's)	Variance (£000's)
Cheshire East	5,134	4,605	529
Cheshire West	5,289	4,552	737
Halton	1,981	2,013	(32)
Knowsley	1,602	1,506	96
Liverpool	6,492	7,111	(619)
Sefton	4,310	4,775	(465)
St Helens	4,293	4,128	165
Warrington	2,259	2,369	(110)
Wirral	5,358	5,283	75
Total	**36,718**	**36,342**	**376**

Continuing Care	Year to Date		
	Budget (£000's)	Actual (£000's)	Variance (£000's)
Cheshire East	15,626	15,438	188
Cheshire West	11,176	11,184	(8)
Halton	3,433	3,559	(126)
Knowsley	2,876	2,714	162
Liverpool	12,204	13,149	(945)
Sefton	10,269	9,540	729
St Helens	5,716	6,149	(433)
Warrington	6,550	6,217	333
Wirral	14,808	15,518	(710)
ICB	0	191	(191)
Total	**82,658**	**83,659**	**(1,001)**

Financial Performance by budget area

Mental Health Packages of Care	Year to Date		
	Budget (£000's)	Actual (£000's)	Variance (£000's)
COMPLEX LEARNING DISABILITIES	7,489	7,672	(183)
COMMUNITY B SUPPORTED HOUSING SERVICES	960	758	202
MENTAL HEALTH PLACEMENTS IN HOSPITALS	5,538	5,513	25
MENTAL HEALTH ACT	18,410	17,915	495
ACUTE MH OOA PLACEMENTS ADULT	1,492	1,705	(213)
ACQUIRED BRIAN INJURY	2,829	2,780	49
TOTAL	**36,718**	**36,343**	**375**

Continuing Care	Year to Date		
	Budget (£000's)	Actual (£000's)	Variance (£000's)
CHC ADULT FULLY FUNDED	34,625	35,977	(1,352)
CHC AD FULL FUND PERS HLTH BUD	12,823	12,448	375
CHC ADULT - FULLY FUNDED - FAST TRACK	10,437	10,468	(31)
CHC AD FULL FUND PERS HLTH BUD - FAST TRACK	543	310	233
ADULT JOINT FUNDED CONTINUING CARE	4,393	4,051	342
ADULT JOINT FUNDED CONTINUING CARE PERSONAL HEALTH BUDGETS	1,306	862	444
CONTINUING HEALTHCARE ASSESSMENT & SUPPORT	3,518	3,278	240
FUNDED NURSING CARE	11,826	13,082	(1,256)
CHILDRENS CONTINUING CARE	2,438	2,591	(153)
CHILDRENS CONTINUING CARE PERSONAL HEALTH BUDGETS	749	592	157
TOTAL	**82,658**	**83,659**	**(1,001)**

Appendix 2 – Agency Expenditure Run Rate – and position vs plan M1 and M2 by provider

	2024/25			2025/26			2025/26			2025/26	
	M10	M11	M12	M1 in month	M1 in month	M1 in month	M2 in month	M2 in month	M2 in month	M2 YTD as a % of paybill	Actual Run Rate Trendline M10-M2
	Actual £,000	Actual £,000	Actual £,000	Plan £,000	Actual £,000	Variance £,000	Plan £,000	Actual £,000	Variance £,000	%	
Alder Hey Children's	67	68	18	79	62	17	79	51	28	0.2%	
Bridgewater Community	91	69	62	112	42	70	109	30	79	0.6%	
Cheshire & Wirral Partnership	515	(317)	560	676	408	268	650	487	163	2.2%	
Countess of Chester Hospitals	219	280	206	315	247	68	315	254	61	1.0%	
East Cheshire Trust	509	453	421	508	339	169	508	270	238	2.3%	
Liverpool Heart & Chest	4	26	39	39	27	12	39	23	16	0.2%	
Liverpool University Hospitals	874	787	924	543	694	(151)	543	853	(310)	1.0%	
Liverpool Women's	95	61	87	32	136	(104)	32	119	(87)	1.3%	
Mersey Care	1,038	980	1,019	900	1,032	(132)	900	921	(21)	1.9%	
Mid Cheshire Hospitals	1,034	1,059	1,176	651	760	(109)	655	628	27	2.6%	
Mersey & West Lancs	1,513	1,223	1,628	927	1,105	(178)	927	1,372	(445)	2.2%	
The Clatterbridge Centre	119	130	148	105	110	(5)	105	98	7	1.0%	
The Walton Centre	58	49	(40)	0	1	(1)	0	33	(33)	0.2%	
Warrington & Halton Hospitals	275	436	394	242	319	(77)	242	119	123	0.9%	
Wirral Community	(26)	46	63	50	42	8	50	39	11	0.6%	
Wirral University Hospitals	732	705	358	588	649	(61)	588	598	(10)	2.1%	
Agency Expenditure	**7,116**	**6,056**	**7,062**	**5,767**	**5,974**	**(207)**	**5,742**	**5,896**	**(154)**	**1.5%**	

Appendix 3 – Bank Expenditure Run Rate – and position vs plan M1 and M2 by provider

	2024/25			2025/26			2025/26			2025/26	
	M10	M11	M12	M1 in month	M1 in month	M1 in month	M2 in month	M2 in month	M2 in month	M2 YTD as a % of paybill	Actual Run Rate Trendline M10-M2
	Actual £,000	Actual £,000	Actual £,000	Plan £,000	Actual £,000	Variance £,000	Plan £,000	Actual £,000	Variance £,000	%	
Alder Hey Children's	684	757	638	475	455	20	475	445	30	1.9%	
Bridgewater Community	65	79	117	100	113	(13)	100	110	(10)	1.8%	
Cheshire & Wirral Partnership	667	685	1,022	722	825	(103)	709	809	(100)	4.0%	
Countess of Chester Hospitals	1,514	1,565	1,840	1,425	1,742	(317)	1,425	1,447	(22)	6.6%	
East Cheshire Trust	1,275	1,207	1,484	1,308	1,302	6	1,280	1,209	71	9.3%	
Liverpool Heart & Chest	326	367	320	267	188	79	267	329	(62)	2.4%	
Liverpool University Hospitals	4,763	5,214	5,180	4,021	4,818	(797)	4,021	4,830	(809)	6.3%	
Liverpool Women's	435	486	299	375	457	(82)	375	471	(96)	4.6%	
Mersey Care	4,064	4,033	5,144	3,051	4,456	(1,405)	3,059	3,537	(478)	7.8%	
Mid Cheshire Hospitals	2,074	1,823	1,978	1,402	1,590	(188)	1,404	1,412	(8)	5.7%	
Mersey & West Lancs	2,811	3,724	4,629	3,659	3,791	(132)	3,659	3,801	(142)	6.8%	
The Clatterbridge Centre	120	(30)	159	83	93	(10)	83	138	(55)	1.1%	
The Walton Centre	399	853	475	372	297	75	391	362	29	3.7%	
Warrington & Halton Hospitals	2,587	1,516	2,908	2,342	2,401	(59)	2,322	2,427	(105)	9.8%	
Wirral Community	342	309	182	252	322	(70)	252	301	(49)	4.7%	
Wirral University Hospitals	2,317	2,204	2,377	1,321	2,239	(918)	2,534	2,134	400	7.3%	
Bank Expenditure	**24,443**	**24,792**	**28,751**	**21,175**	**25,089**	**(3,915)**	**22,356**	**23,762**	**(1,406)**	**6.1%**	

Appendix 4 – Workforce Analysis vs trend and Plan by Provider

	2024/25			2025/26					
Workforce (WTEs) - source PWRs / mitigation plan submission	M10 Actuals	M11 Actuals	M12 Actuals	M1 Actuals	M2 Actuals	M10 to M2 Trend	M2 Plan	M2 Variance to Plan	% var to plan
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	%
Alder Hey Children's	4,426	4,480	4,464	4,346	4,322		4,491	169	3.8%
Bridgewater Community	1,444	1,436	1,422	1,407	1,403		1,444	41	2.9%
Cheshire & Wirral Partnership	4,050	4,095	4,152	4,147	4,080		3,976	(103)	-2.6%
Countess of Chester Hospitals	4,864	4,870	4,920	4,892	4,827		4,792	(34)	-0.7%
East Cheshire Trust	2,672	2,663	2,707	2,652	2,650		2,668	18	0.7%
Liverpool Heart & Chest	1,912	1,934	1,939	1,970	1,982		2,013	30	1.5%
Liverpool University Hospitals	15,104	15,249	15,232	15,114	15,204		15,234	30	0.2%
Liverpool Women's	1,772	1,803	1,842	1,823	1,817		1,791	(26)	-1.4%
Mersey Care	11,616	11,714	11,758	11,836	11,814		11,461	(353)	-3.1%
Mid Cheshire Hospitals	5,529	5,538	5,577	5,502	5,517		5,569	52	0.9%
Mersey & West Lancs	10,575	10,632	10,638	10,631	10,623		10,715	92	0.9%
The Clatterbridge Centre	1,931	1,942	1,957	1,927	1,926		1,919	(7)	-0.4%
The Walton Centre	1,604	1,608	1,619	1,575	1,579		1,564	(15)	-0.9%
Warrington & Halton Hospitals	4,653	4,658	4,692	4,730	4,666		4,762	96	2.0%
Wirral Community	1,560	1,561	1,547	1,535	1,516		1,550	34	2.2%
Wirral University Hospitals	6,336	6,308	6,343	6,293	6,269		6,314	45	0.7%
C&M Providers Total	**80,046**	**80,492**	**80,808**	**80,381**	**80,194**		**80,265**	**70**	**0.1%**
by Sector									
Acute	49,731	49,918	50,108	49,814	49,756		50,055	299	0.6%
Specialist	11,645	11,768	11,821	11,641	11,626		11,778	152	1.3%
Community / MH	18,669	18,806	18,879	18,926	18,812		18,432	(380)	-2.1%
TOTAL Providers	**80,046**	**80,492**	**80,808**	**80,381**	**80,194**		**80,265**	**70**	**0.1%**

Appendix 5 - System Efficiencies: Current Performance M2

Org	CIP delivery (Month 2 YTD)					CIP Recurrent / Non Recurent YTD			Full year CIP				CIP Metrics	
	M2 YTD Plan	M2 YTD Actual	M2 YTD Variance	M2 YTD % Variance	M2 YTD CIP as a % of CIP FOT	M2 YTD Actual Recurrent	M2 YTD Actual Non Recurrent	M2 Actual Recurrent as a % of YTD plan	Full year CIP	FOT	Variance to plan	M2 YTD CIP as a % of CIP FOT	M2 CIP delivery as a % of Op Ex	CIP FOT as % of Op Ex
	£,000	£,000	£,000	%	%	£,000	£,000	%	£,000	£,000	£,000	%	%	%
Alder Hey Children's	2,799	1,608	(1,191)	-43%	7%	720	888	26%	22,746	22,746	0	7%	2.2%	5.1%
Bridgewater Commu	760	760	0	0%	14%	760	-	100%	5,475	5,475	0	14%	4.2%	5.2%
Cheshire & Wirral Pa	1,975	836	(1,139)	-58%	6%	731	105	37%	14,856	14,852	(4)	6%	1.6%	5.0%
Countess of Chester	2,032	726	(1,306)	-64%	3%	726	-	36%	27,703	27,703	0	3%	1.0%	5.9%
East Cheshire Trust	1,686	1,686	(0)	0%	14%	716	970	42%	12,175	12,175	(0)	14%	4.1%	5.1%
Liverpool Heart & Ch	1,647	849	(798)	-48%	6%	368	481	22%	13,499	13,499	0	6%	2.0%	5.2%
Liverpool University H	13,571	18,931	5,360	39%	16%	12,854	6,077	95%	117,185	117,185	(0)	16%	7.8%	8.3%
Liverpool Women's	1,350	1,312	(38)	-3%	10%	722	590	53%	12,680	12,680	0	10%	4.0%	6.3%
Mersey Care	5,622	4,989	(633)	-11%	12%	3,453	1,536	61%	40,696	40,692	(4)	12%	3.8%	5.0%
Mid Cheshire Hospita	3,997	3,423	(574)	-14%	11%	1,762	1,661	44%	31,668	31,083	(585)	11%	4.3%	6.5%
Mersey & West Lancs	7,368	7,368	0	0%	15%	2,580	4,788	35%	48,200	48,200	(0)	15%	4.3%	4.9%
The Clatterbridge Ce	2,048	858	(1,190)	-58%	6%	544	314	27%	14,790	14,790	0	6%	1.5%	4.6%
The Walton Centre	1,742	1,742	0	0%	14%	1,548	195	89%	12,247	12,247	0	14%	5.0%	5.9%
Warrington & Halton	1,676	1,676	0	0%	8%	992	685	59%	21,477	21,477	(1)	8%	2.4%	5.1%
Wirral Community	700	713	12	2%	12%	713	-	102%	5,702	5,758	56	12%	3.9%	5.2%
Wirral University Hos	5,337	5,336	(1)	0%	17%	2,620	2,716	49%	32,020	32,020	0	17%	5.9%	5.9%
TOTAL Providers	**54,310**	**52,813**	**(1,497)**	**-3%**	**12%**	**31,808**	**21,005**	**59%**	**433,118**	**432,582**	**(537)**	**12%**	**4.3%**	**7.0%**
C&M ICB	8,616	8,228	(388)	-5%	6%	8,228	-	95%	139,352	143,585	4,233	6%	5.3%	7.5%
TOTAL ICS System	**62,926**	**61,041**	**(1,885)**	**-3%**	**11%**	**40,036**	**21,005**	**64%**	**572,470**	**576,167**	**3,159**	**11%**	**4.4%**	**7.1%**

Appendix 6 – System Efficiencies – Full Year Maturity / Development Status as at M2

	In Year CIP maturity - Month 2 reporting								
	Fully Developed £,000	Plans in Progress £,000	Opportunity £,000	Unidentified £,000	Total Efficiencies £,000	Fully Developed £,000	Plans in Progress £,000	Opportunity £,000	Unidentified £,000
Cheshire And Merseyside ICB	84,389	32,852	26,344	0	**143,585**	59%	23%	18%	0%
Alder Hey Children's	9,504	2,764	10,478	-	**22,746**	42%	12%	46%	0%
Bridgewater Community	3,391	2,084	-	-	**5,475**	62%	38%	0%	0%
Cheshire & Wirral Partnership	4,935	9,417	500	-	**14,852**	33%	63%	3%	0%
Countess of Chester Hospitals	5,941	5,821	7,207	8,734	**27,703**	21%	21%	26%	32%
East Cheshire Trust	8,854	1,032	2,289	-	**12,175**	73%	8%	19%	0%
Liverpool Heart & Chest	7,424	2,233	3,046	796	**13,499**	55%	17%	23%	6%
Liverpool University Hospitals	95,422	-	21,763	-	**117,185**	81%	0%	19%	0%
Liverpool Women's	6,513	2,785	3,381	-	**12,680**	51%	22%	27%	0%
Mersey Care	31,493	8,607	330	262	**40,692**	77%	21%	1%	1%
Mid Cheshire Hospitals	14,904	13,493	2,686	-	**31,083**	48%	43%	9%	0%
Mersey & West Lancs	22,097	16,303	9,800	-	**48,200**	46%	34%	20%	0%
The Clatterbridge Centre	6,761	3,229	4,800	-	**14,790**	46%	22%	32%	0%
The Walton Centre	8,997	2,260	991	-	**12,247**	73%	18%	8%	0%
Warrington & Halton Hospitals	12,200	614	8,663	-	**21,477**	57%	3%	40%	0%
Wirral Community	4,643	541	575	-	**5,758**	81%	9%	10%	0%
Wirral University Hospitals	26,276	4,609	1,135	-	**32,020**	82%	14%	4%	0%
TOTAL C&M ICS	**353,745**	**108,643**	**103,987**	**9,792**	**576,167**	**61%**	**19%**	**18%**	**2%**

Appendix 7: Provider Cash at Month 2

Org	Cash Balance			Operating Days Cash Actual and Forecast*									DHSC External Cash Support - Revenue		BPPC % of bills paid in target	
	2024/25 M12 Closing Cash Balance	2025/26 M2 Closing Cash Balance	Movement	24/25 M10 Actual	24/25 M11 Actual	24/25 M12 Actual	25/26 M2 Actual	25/26 M3 Forecast	25/26 M4 Forecast	25/26 M5 Forecast	25/26 M6 Forecast	Trend	M2 YTD	FOT	2024/25 M2 By number	2024/25 M2 By Value
	£m	£m	£m	Days	Days	Days	Days	Days	Days	Days	Days		£m	£m	%	%
Alder Hey Children's	53.7	38.1	(15.6)	53	46	34	35	28	23	21	20		0.0	0.0	92.4%	88.8%
Bridgewater Community	8.2	5.7	(2.5)	29	33	20	22	26	22	16	10		0.0	0.0	98.4%	98.9%
Cheshire & Wirral Partnership	28.5	24.0	(4.5)	44	41	28	31	31	31	31	27		0.0	0.0	98.3%	97.7%
Countess of Chester Hospitals	28.2	15.8	(12.4)	4	29	17	14	9	9	(1)	(9)		0.0	8.0	94.6%	94.3%
East Cheshire Trust	14.0	10.9	(3.1)	20	32	15	18	17	13	7	7		0.0	0.0	96.9%	97.0%
Liverpool Heart & Chest	49.4	48.1	(1.2)	62	66	58	76	75	80	80	79		0.0	0.0	98.0%	99.3%
Liverpool University Hospitals	30.4	30.2	(0.3)	2	8	6	8	5	4	4	1		0.0	0.0	74.4%	90.3%
Liverpool Women's	3.8	5.3	1.4	15	13	6	11	6	2	(2)	(5)		0.0	15.0	95.2%	97.1%
Mersey Care	53.8	49.4	(4.4)	29	27	17	24	22	21	20	7		0.0	0.0	95.4%	96.9%
Mid Cheshire Hospitals	36.3	35.0	(1.3)	34	41	21	30	27	25	27	23		0.0	0.0	95.4%	94.8%
Mersey & West Lancs	10.2	3.7	(6.5)	1	3	3	1	1	0	(0)	(1)		0.0	19.0	93.5%	95.5%
The Clatterbridge Centre	73.2	69.5	(3.6)	85	82	63	79	87	93	95	91		0.0	0.0	97.3%	99.1%
The Walton Centre	62.4	51.3	(11.2)	111	103	83	99	100	107	110	108		0.0	0.0	90.0%	96.1%
Warrington & Halton Hospitals	16.3	12.9	(3.4)	14	11	11	12	16	14	12	5		0.0	15.3	48.5%	48.8%
Wirral Community	7.8	10.5	2.7	37	37	19	39	36	38	37	34		0.0	0.0	90.4%	94.6%
Wirral University Hospitals	0.1	4.2	4.1	3	3	0	3	1	5	4	0		8.0	19.5	81.6%	91.0%
TOTAL Providers	**476.2**	**414.5**	**(61.7)**			**18**	**23**	**21**	**21**	**20**	**18**		**8.0**	**76.8**	**90.0%**	**92.5%**

* the Forecast Operating Days assumes no receipt of External Cash support via NHS England's Revenue Support PDC process - this was a per NHSE month 2 reporting guidance

** the Forecast does include revenue Deficit Support Funding via ICB

Appendix 8: **Provider BPPC at Month 2**

Better Payment Pratice Code (BPPC)	BPPC % of bills paid within 95% target By Number					BPPC % of bills paid within 95% target By Value				
	24/25 M10 %	24/25 M11 %	24/25 M12 %	25/26 M2 %	Trend	24/25 M10 %	24/25 M11 %	24/25 M12 %	25/26 M2 %	Trend
Alder Hey Children's	93.3%	93.3%	93.2%	92.4%		91.8%	91.8%	91.5%	88.8%	
Bridgewater Community	98.2%	98.3%	98.4%	98.4%		98.2%	98.5%	98.4%	98.9%	
Cheshire & Wirral Partnership	95.8%	95.9%	96.2%	98.3%		93.0%	93.3%	93.9%	97.7%	
Countess of Chester Hospitals	95.2%	95.1%	95.0%	94.6%		95.2%	95.2%	95.4%	94.3%	
East Cheshire Trust	93.3%	93.6%	93.8%	96.9%		91.3%	91.8%	92.4%	97.0%	
Liverpool Heart & Chest	97.2%	97.3%	97.4%	98.0%		98.1%	98.1%	98.2%	99.3%	
Liverpool University Hospitals	76.8%	76.9%	76.6%	74.4%		91.3%	91.2%	90.9%	90.3%	
Liverpool Women's	93.5%	93.1%	93.4%	95.2%		95.2%	94.9%	94.7%	97.1%	
Mersey Care	95.4%	95.5%	95.5%	95.4%		96.1%	96.0%	96.0%	96.9%	
Mid Cheshire Hospitals	94.5%	94.6%	94.7%	95.4%		94.4%	94.5%	94.4%	94.8%	
Mersey & West Lancs	84.3%	85.0%	85.7%	93.5%		92.0%	92.3%	92.6%	95.5%	
The Clatterbridge Centre	97.9%	97.9%	97.7%	97.3%		98.9%	98.9%	98.9%	99.1%	
The Walton Centre	93.1%	93.0%	88.8%	90.0%		93.4%	92.9%	90.7%	96.1%	
Warrington & Halton Hospitals	87.0%	87.0%	87.3%	48.5%		92.9%	93.3%	92.9%	48.8%	
Wirral Community	91.9%	91.9%	92.3%	90.4%		95.2%	95.5%	95.8%	94.6%	
Wirral University Hospitals	57.8%	61.3%	60.2%	81.6%		74.6%	76.0%	76.0%	91.0%	
Average C&M Providers	**90.3%**	**90.6%**	**90.4%**	**90.0%**		**93.2%**	**93.4%**	**93.3%**	**92.5%**	

Appendix 9: Provider Capital Expenditure vs ICS Allocation at Month 2

	Plan YTD	Actual YTD	Variance YTD	Plan Year Ending	Forecast Year Ending	Variance Year Ending	
	£'000	£'000	£'000	£'000	£'000	£'000	%
Alder Hey Children'S NHS Foundation Trust	6,225	6,885	(660)	13,377	13,377	-	0.0%
Bridgewater Community Healthcare NHS Foundation Trust	1,597	-	1,597	4,542	4,542	-	0.0%
Cheshire And Wirral Partnership NHS Foundation Trust	1,871	1,427	444	8,522	8,522	-	0.0%
Countess Of Chester Hospital NHS Foundation Trust	3,249	291	2,958	10,289	10,289	-	0.0%
East Cheshire NHS Trust	3,727	1,519	2,208	10,362	10,362	-	0.0%
Liverpool Heart And Chest Hospital NHS Foundation Trust	1,635	894	741	7,935	7,935	-	0.0%
Liverpool University Hospitals NHS Foundation Trust	3,782	924	2,858	47,587	47,587	-	0.0%
Liverpool Women'S NHS Foundation Trust	-	516	(516)	6,888	6,888	-	0.0%
Mersey and West Lancashire Teaching Hospitals NHS Trust	7,110	214	6,896	30,962	30,962	-	0.0%
Mersey Care NHS Foundation Trust	8,229	7,950	279	21,879	21,879	-	0.0%
Mid Cheshire Hospitals NHS Foundation Trust	1,840	417	1,423	10,962	10,961	1	0.0%
The Clatterbridge Cancer Centre NHS Foundation Trust	-	525	(525)	9,809	9,809	-	0.0%
The Walton Centre NHS Foundation Trust	1,167	480	687	9,520	9,520	-	0.0%
Warrington And Halton Teaching Hospitals NHS Foundation	746	366	380	11,932	11,932	0	0.0%
Wirral Community Health And Care NHS Foundation Trust	869	488	381	3,772	3,772	0	0.0%
Wirral University Teaching Hospital NHS Foundation Trust	2,239	635	1,604	13,451	13,451	-	0.0%
-	-	-	-	-	-	-	0.0%
Total Provider charge against allocation	44,285	23,530	20,755	221,789	221,788	1	0.0%
Capital allocation					221,788		
Variance to allocation					(0)		
Allocation met					Yes		

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

Highlight report of the Chair of the Finance, Investment & Resource Committee

Agenda Item No: ICB/07/25/07

Committee Chair: Mike Burrows, ICB Non-Executive Member

NHS
Cheshire and Merseyside

Highlight report of the Chair of the Finance, Investment & Resource Committee

Committee Chair	Mike Burrows
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Meeting date	20 May 2025

Key escalation and discussion points from the Committee meeting

Alert

At its meeting in May 2025 the Committee considered:

- **Month 1 and 2 position**
  For Month 2 the system has reported at YTD deficit of £67,1m, against a planned YTD deficit of £67.3m resulting in a favourable YTD variance of £0.2m. Key risks within this position include:
  - Shortfall in CIP of £1.9m, offset by non-recurrent gains such as use of balance sheet or vacancy-hold.
  - Reliance on non-recurrent CIP of £32m out of £61m
  - Bank costs remain above plan by £5.3m
  - 3 Trusts with cash operating dahs less than 10: LUHFT, MWL, and WUTH, with LWH and COCH to fall below 10 days in June.

Advise

At its meeting in May 2025 the Committee considered:

- **Turnaround update**
  - PWC undertaking diagnostic, due to report in next fortnight
  - Simon Worthington reviewing CIP in conjunction with NHSE regional team
  - CHC collaboration with local authorities identified as a pressing issue.
  - Reports to be shared at July FIRC.

- **Contracting update**
  - Adopted approach to re-construct contracts utilising new tariff, leading to revised “system top-up” calculations. There are some local issues arising from this approach, which we expect to be resolved without escalation.
  - Approach is a key foundation of the 3 year medium term financial plans.
  - Funding for Southport Community Diagnostic Centre remains an issue and has been escalated to the regional team for their consideration.

- **FCOG update**
  - ICB forecast savings total £143.7m, above planned target of £139m. Primary care, Commissioning and community equipment over-delivering.
  - CHC remains a challenge.

Assure
At its meeting in May 2025 the Committee considered: • **Procurement** Authority given to proceed with re-procurement of NEPTS. Noted need to take into account PTS services purchased across the system, and ensure the new contract addresses concerns and issues with current service

Committee risk management

Overall review of Risk assessment processes and reporting is underway and will report more fully to FIRC in July.

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
Deliver of financial savings through productivity and reducing Waste	FCOG update
Delivery of the financial position	Month 1 and Month 2 report
Development and delivery of the Capital Plans.	Month 1 and Month 2 report
Development of System Estates Plans to deliver a programme to review and rationalise our corporate estates.	Estates Strategy update due in July

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

Integrated Performance Report

Agenda Item No: ICB/07/25/08

Responsible Director: Anthony Middleton
Director of Performance and Planning

Integrated Performance Report

1. Purpose of the Report

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

2. Executive Summary

2.1 The integrated performance report for July 2025, see appendix one, provides an overview of key metrics drawn from the 2024/25 Operational plans, specifically covering Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance.

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

3. Ask of the Board and Recommendations

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

4. Reasons for Recommendations

4.1 The report is sent for assurance.

5. Background

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

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.

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

9.3 Additionally, there is a risk that the system will be unable to deliver timely and effective urgent and emergency care services due to rising demand, workforce pressures, capacity constraints, and delayed patient discharges. This may result in non-compliance with key NHS 2025/26 planning guidance standards, including the 4-hour ED target, 12-hour decision-to-admit (DTA) breaches, and ambulance handover delays. These risks may contribute to patient harm, regulatory scrutiny, and reputational damage. This maps to Board Assurance Framework Risk P15.

10. Finance

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

11. Communication and Engagement

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

12. Equality, Diversity and Inclusion

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

13. Climate Change / Sustainability

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

14. Next Steps and Responsible Person to take forward

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

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

24th July 2025

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Integrated Quality & Performance Report – Guidance:

NHS Cheshire and Merseyside

Provider Acronyms:

ACUTE TRUSTS		SPECIALIST TRUSTS		COMMUNITY AND MENTAL HEALTH TRUSTS		KEY SYSTEM PARTNERS	
COCH	COUNTESS OF CHESTER HOSPITAL NHS FT	AHCH	ALDER HEY CHILDREN'S HOSPITAL NHS FT	BCHC	BRIDGEWATER COMMUNITY HEALTHCARE NHS FT	NWAS	NORTH WEST AMBULANCE SERVICE NHS TRUST
ECT	EAST CHESHIRE NHS TRUST	LHCH	LIVERPOOL HEART AND CHEST HOSPITAL NHS FT	WCHC	WIRRAL COMMUNITY HEALTH AND CARE NHS FT	CMCA	CHESHIRE AND MERSEYSIDE CANCER ALLIANCE
MCHT	MID CHESHIRE HOSPITALS NHS FT	LWH	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	MCFT	MERSEY CARE NHS FT	**OTHER**	
LUFT	LIVERPOOL UNIVERSITY HOSPITALS NHS FT	TCCC	THE CLATTERBRIDGE CANCER CENTRE NHS FT	CWP	CHESHIRE AND WIRRAL PARTNERSHIP NHS FT	OOA	OUT OF AREA AND OTHER PROVIDERS
MWL	MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	TWC	THE WALTON CENTRE NHS FT				
WHH	WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT						
WUTH	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT						

Key:

Data formatting

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

C&M National Ranking against the 42 ICBs

≤11th	C&M in top quartile nationally
12th to 31st	C&M in interquartile range nationally
≥32nd	C&M in bottom quartile nationally
-	Ranking not appropriate/applied nationally

C&M National Ranking against the 22 Cancer Alliances

≤5th	C&M in top quartile nationally
6th to 17th	C&M in interquartile range nationally
≥18th	C&M in bottom quartile nationally
-	Ranking not appropriate/applied nationally

Notes on interpreting the data

Latest Period: The most recently published, validated data has been used in the report, unless more recent provisional data is available that has historically been reliable. In addition, some metrics are only published quarterly, half yearly or annually - this is indicated in the performance tables.

Historic Data: To support identification of trends, up to 13 months of data is shown in the tables, the number of months visible varies by metric due to differing publication timescales.

Local Trajectory: The C&M operational plan has been formally agreed as the ICBs local performance trajectory and may differ to the national target

RAG rating: Where local trajectories have been formalised the RAG rating shown represents performance against the agreed local trajectories, rather than national standards. It should also be noted that national and local performance standards do change over time, this can mean different months with the same level of performance may be RAG rated differently.

National Ranking: Ranking is only available for data published and ranked nationally, therefore some metrics do not have a ranking, including those where local data has been used.

Target: Locally agreed targets are in **Bold Turquoise**. National Targets are in **Bold Navy**.

Integrated Quality & Performance Report – Interpreting SPC Charts:

NHS
Cheshire and Merseyside

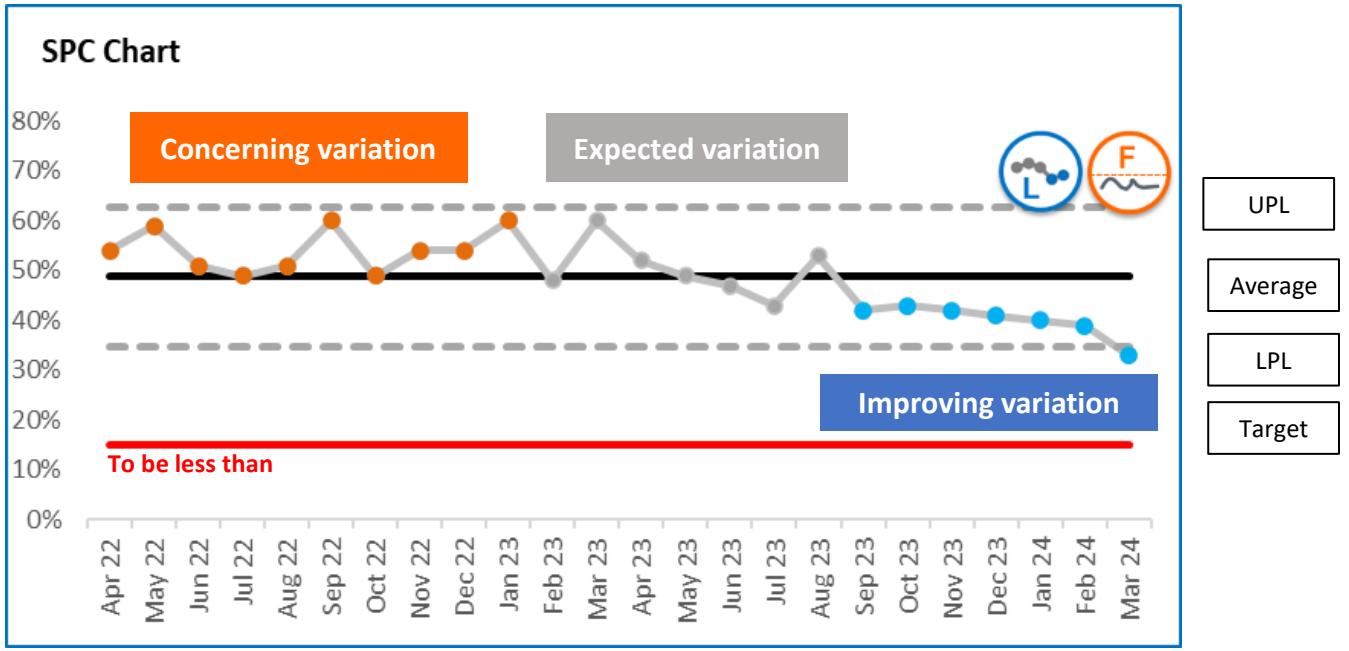
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated, and improvement actions implemented

Blue – there is a pattern of improvement which should be learnt from

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable



UPL

Average

LPL

Target

The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the **red** line) can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

Integrated Quality & Performance Report – Interpreting summary icons:

NHS Cheshire and Merseyside

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

	Variation / performance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart, you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	**Something's going on!** Something, a one-off or a continued trend or shift of numbers in the wrong direction	**Investigate** to find out what is happening or has happened. Is it a one-off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	**Something good is happening!** Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening or has happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?

	Assurance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits, then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is the target will be achieved or missed at random.	Consider whether this is acceptable and, if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction,** then you know the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction,** then you know the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Local Trajectory	National Target	Region value	National value	Latest Rank
Urgent care	4-hour A&E waiting time (% waiting less than 4 hours)	Jun-25	71.1%	72.7%	74.4%	74.3%	72.9%	72.3%	72.4%	71.4%	72.9%	73.1%	72.6%	72.7%	73.7%	73.0%	73.5%	78% by Year end	72.4%	75.5%	29/42
	Ambulance category 2 mean response time	Jun-25	00:33:02	00:34:47	00:37:59	00:24:58	00:38:08	00:56:23	00:52:34	01:06:45	00:52:51	00:38:28	00:32:43	00:27:58	00:26:44	00:30:22	-	00:30:00	00:25:39	00:29:37	22/42
	Mean Ambulance Handover time (ED and Non ED) (NEW)	Jun-25	00:35:46	00:37:03	00:38:45	00:32:05	00:44:08	00:52:35	00:50:58	00:55:51	00:47:53	00:39:09	00:34:32	00:34:23	00:31:57	00:32:58	00:39:45	00:15:00	00:28:19	00:28:51	28/42
	A&E 12 hour waits from arrival	Jun-25	16.8%	15.8%	15.6%	15.5%	16.6%	17.0%	15.7%	18.3%	18.3%	17.4%	16.2%	15.9%	16.6%	16.8%	16.4%	-	12.5%	8.8%	40/42
	Adult G&A bed occupancy	Jun-25	95.8%	95.9%	95.5%	94.9%	95.6%	96.3%	96.5%	96.0%	97.4%	97.2%	95.9%	96.4%	96.5%	95.8%		92.0%	94.6%	94.1%	32/42
	Discharges - Average delay (exclude zero delay) (NEW)	May-25					10.5	9.2	9.0	8.8	9.5	9.0	10.1	9.8	8.8		9.3		7.2	6.0	37/42
	Percentage of patients discharged on discharge ready date (NEW)	May-25					88.1%	89.0%	87.8%	89.1%	88.2%	89.0%	89.0%	88.3%	88.3%		85.0%		86.6%	86.1%	14/42
Planned care	Total incomplete Referral to Treatment (RTT) pathways	May-25	369,179	368,967	370,607	372,357	369,065	367,350	366,053	361,746	358,637	356,570	360,184	354,386	350,979		361,635	-	1,017,949	7,359,457	-
	The % of people waiting less than 18 weeks on the waiting list (RTT) (NEW)	May-25	57.7%	57.4%	57.1%	56.3%	56.2%	56.9%	57.4%	56.7%	56.5%	57.3%	58.0%	58.0%	59.1%		58.0%	92.0%	58.4%	60.9%	29/42
	The % of people waiting more than 52 weeks on the waiting list (RTT) (NEW)	May-25	4.0%	4.0%	4.0%	4.1%	3.7%	3.5%	3.4%	3.3%	3.4%	3.3%	3.0%	3.5%	3.7%		3.2%		3.4%	2.7%	38/42
	Number of 52+ week RTT waits, of which children under 18 years.	May-25	1,505	1,542	1,493	1,295	1,029	1,063	886	902	922	919	750	972	983		959	-	n/a	n/a	-
	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	May-25	2,331	2,285	2,098	1,972	985	1,091	1,093	1,282	1,167	1,091	659	990	1,443		-	-	2,022	11,522	-
	Patients waiting more than 6 weeks for a diagnostic test	May-25	10.0%	10.1%	9.0%	10.1%	8.8%	7.2%	6.9%	10.3%	11.2%	5.9%	6.7%	10.1%	12.0%		5.0%	5.0%	15.3%	22.0%	3/42
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Apr-25	71.8%	72.1%	75.9%	74.6%	73.0%	73.8%	75.9%	74.9%	71.6%	74.7%	76.4%	76.1%			72.8%	85.0%	72.5%	69.8%	4/42
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Apr-25	95.4%	94.5%	94.8%	94.3%	93.3%	94.6%	94.2%	95.5%	92.8%	95.8%	95.3%	94.7%			96.0%	96.0%	94.1%	91.3%	11/42
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Apr-25	71.4%	73.8%	74.1%	73.2%	71.4%	73.3%	75.4%	75.5%	66.8%	76.6%	76.3%	75.4%			77.2%	77% by Year end	76.3%	76.7%	31/42
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028. (rolling 12 months)	Feb-25	57.7%	57.8%	57.8%	58.2%	58.8%	58.9%	59.1%	59.3%	59.3%	59.5%					70.0%	75% by 2028	58.5%	59.1%	23/42
Mental Health	Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Apr-25	20,665	20,690	20,880	20,870	21,000	21,205	21,265	21,440	21,605	21,730	21,770	22,040					55730	620772	-
	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Apr-25	78%	78%	76%	75%	73%	75%	76%	78%	79%	79%	83%	77%			60.0%	60.0%	73.0%	66.9%	19/42
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	To Mar 2025	55.0%			52.0%			52.0%			62.0%					-	60.0%	65.0%	66.0%	30/42
	Dementia Diagnosis Rate	May-25	67.2%	67.4%	67.7%	67.6%	67.4%	67.6%	67.4%	67.3%	67.2%	67.4%	67.6%	67.6%	67.6%		66.7%	66.7%	70.0%	65.6%	15/42
	CYP Eating Disorders Routine	Apr-25	79.0%	71.0%	79.0%	77.0%	79.0%	84.0%	87.0%	89.0%	88.0%	87.0%	86.0%	92.0%			95.0%	95.0%	83.0%	76.9%	5/42
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact (NEW)	Apr-25	35,140	35,220	35,105	34,655	34,660	34,730	35,000	34,550	34,710	34,550	34,625	35,450			37246	-	122950	842333	-
	Number of people accessing specialist Community PMH and MMHS services (NEW)	Apr-25	3,260	3,280	3,335	3,370	3,420	3,480	3,505	3,555	3,530	3,555	3,625	3,620			3420	-	8965	64805	-
	Talking Therapies completing a course of treatment - % of plan achieved	Apr-25	98.6%	93.6%	93.0%	93.0%	93.1%	95.0%	94.0%	92.0%	92.0%	92.0%	91.0%	102.0%			100.0%	100.0%	79.0%	100.0%	20/42
	Talking Therapies Reliable Recovery	Apr-25	46.0%	41.0%	47.0%	46.0%	46.0%	48.0%	48.0%	45.0%	47.0%	47.0%	49.0%	48.0%			48.0%	48.0%	48.0%	48.4%	22/42
	Talking Therapies Reliable Improvement	Apr-25	67.0%	50.0%	66.0%	65.0%	65.0%	66.0%	66.0%	65.0%	66.0%	68.0%	68.0%	67.0%			67.0%	67.0%	68.0%	68.7%	34/42
Note/s	* No local plan for 2025/26																				

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Local Trajectory	National Target	Region value	National value	Latest Rank
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	May-25	95	100	100	95	90	85	85	85	80	80	80	80	75		50	-	235	1,785	22/42
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Apr 25 YTD	7.2%	12.0%	17.7%	23.8%	29.8%	37.6%	45.7%	52.7%	63.0%	73.3%	85.5%	3.1%			3.3%	**75%** by Year end	3.4%	3.4%	29/42
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Apr-25	87%	85%	84%	86%	85%	86%	83%	85%	84%	83%	85%	86%			70.0%	**70.0%**	87.0%	85.0%	25/42
	Virtual Wards Utilisation	May-25	39%	70%	67%	62%	74.6%	93.2%	75.2%	69.2%	94.7%	73.5%	83.1%	75.3%	74.7%		80.0%	**80.0%**	66.7%	75.0%	20/42
	Community Services Waiting List (Adults)	Apr-25	53,285	49,459	54,375	54,021	54,830	48,815	48,663	50,574	50,937	41,919	43,198	42,897					88,920	799,346	-
	Community services Waiting List (CYP)	Apr-25	24,712	25,209	25,378	24,426	23,542	21,747	22,890	22,834	23,164	20,184	20,110	20,519					45,417	322,510	-
	Community Services – Adults waiting over 52 weeks	Apr-25	308	329	359	382	433	435	411	234	164	94	118	95			1		528	12,306	-
Primary Care	Units of dental activity delivered as a proportion of all units of dental activity contracted	May-25	81.0%	80.0%	79.0%	77.0%	82.0%	86.0%	88.0%	78.0%	82.0%	94.0%	95.0%	82.0%	78.0%		80.0%	**100.0%**	86.0%	86.0%	34/42
	Number of unique patients seen by an NHS Dentist – Adults (24 month)	May-25	926,012	926,430	928,591	928,716	929,925	932,009	932,314	933,534	934,964	936,873	937,773	940,347	939,940		940,075		2,647,394	18,120,588	-
	Number of unique patients seen by an NHS Dentist – Children (12 month)	May-25	323,306	323,089	325,212	325,733	327,329	329,456	330,255	331,503	332,275	332,480	333,475	333,572	332,921		334,258		1,018,575	7,130,162	-
	Appointments in General Practice & Primary Care networks (NEW)	Apr-25	1,281,078	1,186,608	1,300,504	1,171,799	1,253,935	1,649,116	1,319,968	1,191,861	1,401,109	1,258,627	1,342,136	1,237,568			1,294,229		-	-	-
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Mar-25	7.17%	7.12%	7.08%	7.07%	7.06%	6.94%	6.94%	6.94%	6.98%	7.02%	7.09%				10.0%	**10.0%**	-	7.62% (Dec 24)	-
	Total volume of antibiotic prescribing in primary care	Mar-25	1.04	1.04	1.04	1.03	1.02	1.02	1.01	1.01	0.99	0.98	0.97				0.871	**0.871**	-	1.00	-
Integrated care - BCF metrics	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (average of place rates)***	Q3 24/25	235.7		231.5			228.6									-	-	237.7	198.9	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Mar-25	93.4%	93.3%	93.0%	93.3%	93.3%	93.2%	93.2%	93.4%	92.8%	93.4%	93.3%				-	-	92.4%	93.0%	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (average of place rates)***	Q3 24/25	535.3		526.1			542.5									-	-	346.4	351.0	-
Specialised Commissioning	Cardiac Treatment waiting list (LH&CH) #	May-25	418	425	450	407	410	414	390	401	389	386	376	363	383		396				-
	Neurosurgery waiting list (TWC) #	May-25	786	895	858	853	885	876	929	914	927	921	967	974	950		849				-
	Specialised Paediatrics waiting list (AHCH) #	May-25	365	352	350	356	287	312	265	261	256	269	248	238	221		363				-
	Vascular waiting list (LUFT) #	May-25	197	171	176	160	145	145	163	153	166	167	180	160	183		196				-
Note/s	*** Awaiting clarification from NHSE re: metric criteria. Plans are no longer comparable to actuals largely due to implementation of SDEC (Type 5) in year but also revisions to National crtieria which systems need time to adopt and validate. # RAG rating based on 12 month comparison (Red = Higher, Green = Lower)																				

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Local Trajectory	National Target	Region value	National value	Latest Rank
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q3 24/25	65.8%		65.6%			65.50%									77.0%	80.0%	66.53%	67.2%	29/42
	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with lipid lowering therapies	Q3 24/25	62.2%		62.3%			62.6%										65.0%	61.1%	62.74%	19/42
	Smoking at Time of Delivery V2	Q4 24/25	7.3%		6.8%			6.1%			5.9%							<6%	5.7%	5.10%	31/42
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.~	Mar-25	13.8%	13.7%	13.6%	13.7%	13.7%	13.6%	13.6%	13.5%	13.5%	13.4%					12.0%	12.0%	-	12.7%^	-
Continuing Healthcare	Standard Referrals completed within 28 days	Q4 24/25	71.70%		64.70%			73.10%			76%						>80%	>80%	82.5%	77.1%	27/42
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q4 24/25	28.75		29.15			27.18			27.04						<18		22.41	17.50	38/42
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q4 24/25	51.69		53.36			53.85			54.67						<34		47.05	33.34	39/42
Maternity	HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks)	Q4 24/25	0.7		1.1			0.9			0.5						2.5	2.5	0.8		
	Still birth per 1,000 (rolling 12 months)	Mar-25	2.58	2.83	2.71	2.45	2.48	2.64	2.53	2.72	3.02	3.11	2.95				-	-	-	3.8	-
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Place aggregation (Healthcare & Community associated) (NEW)	12 months to Apr 25	1022	1047	1031	1097	1118	1156	1176	1205	1198	1210	1191	1155			843		3262	18873	
	Healthcare Acquired Infections: E.Coli Place aggregation (Healthcare & Community associated) (NEW)	12 months to Apr 25	2270	2267	2280	2307	2318	2359	2357	2367	2352	2333	2330	2330			2001		5978	43741	
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation #	Jan-25	0.993	0.999	0.991	0.992	0.988	0.989	0.984	0.986	0.997						0.887 to 1.127 *		-	1.000	-
	Never Events	Jun-25	2	2	1	1	1	0	3	0	6	1	2	0	5	3	0	0	-	-	-
Workforce / HR (ICS total)	Staff in post	May-25	73,011	72,945	72,909	73,039	73,548	73,910	74,068	74,101	74,208	74,450	74,600	74,524	74,472		74,589	-			
	Bank	May-25	5,262	4,833	5,339	5,255	5,122	5,084	4,868	4,848	5,000	5,289	5,459	5,213	5,098		4,804	-			
	Agency	May-25	1,088	1,072	1,104	1,009	932	1,009	886	824	838	775	749	644	624		871.1	-			
	Turnover	Mar-25	11.2%	11.3%	11.0%	11.0%	10.9%	10.9%	10.8%	10.7%			10.4%				11.4%	-			
	Sickness	Mar-25	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%			6.1%				5.8%	-			
Note/s	* National average upper and lower control limits (UCL and LCL) for SHMI across all non-specialist trusts. This gives an indication of whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, for C&M was as expected when compared to the national baseline. This "rate" is different to the SHMI "banding" used for trusts on slide 8, therefore a comparison cannot be drawn between the two. ^ National figure is the latest ONS figure from 2022. local data is directly from GP systems. this has been reviewed against historic ONS data for LA's and the variation ranges from -0.9% to +5.9% # Banding changed Aug 23 to reflect SOF bandings for providers. Green = no providers higher than expected, Amber = 1-2 providers higher than expected, Red = more than 2 providers higher than expected ** -From December 2023 this metric is now available at ICB level, previously this was only reported at Cancer Alliance level. historical data has been updated ~ Data issue resolved, new data will be available from June 25																				

2. ICB Aggregate Financial Position

NHS Cheshire and Merseyside

ICB Overall Financial Position:

Category	Metric	Latest period	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Plan (£m)	Dir. Of Travel	FOT (£m) Plan	FOT (£m) Current	FOT (£m) Variance
Finance	Financial position £m (ICS) ACTUAL	May-25	-68.8	-101.0	-138.0	-166.9	-108.5	-112.9	-129.5	-129.7	-109.7	-89.7	-45.9	-	-37.4	-37.6	-	0.0	0.0	0.0
	Financial position £ms (ICS) VARIANCE	May-25	-19.1	-16.5	-38.5	-48.5	-48.8	-51.4	-67.4	-61.2	-47.3	-33.2	-45.9	-	0.2		-			
	Efficiencies £ms (ICS) ACTUAL	May-25	41.9	64.7	92.3	119.9	156.4	192.9	235.3	276.6	321.3	362.7	417.1	-	61.0	62.9	-	572.5	576.2	3.7
	Efficiencies £ms (ICS) VARIANCE	May-25	-15.2	-13.1	-20.2	-26.6	-25.0	-26.7	-22.5	-20.7	-23.4	-29.4	-22.8	-	-1.9		-			
	Capital £ms (ICS) ACTUAL	May-25	N/A	39.5	65.6	81.8	97.1	121.7	145.0	170.0	204.1	241.0	327.0	-	-	-	-	249.5	249.5	0.0
	Capital £ms (ICS) VARIANCE	May-25	N/A	3.9	11.3	13.6	26.8	28.3	28.2	32.1	24.6	10.9	-16.7	-	-	-	-			

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

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

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Urgent care	4-hour A&E waiting time % waiting less than 4 hours	Jun-25	63.7%	46.7%	59.1%	73.4%	69.2%	73.6%	78.9%	91.1%	-	92.6%	-	-	-	-	-	-	-	73.0%
	Mean Ambulance Handover time (ED and Non ED) (NEW)	Jun-25	00:29:02	00:35:02	00:31:04	00:34:04	00:32:51	00:40:51	00:25:04	00:24:15										00:32:58
	A&E 12 hour waits from arrival	Jun-25	22.1%	**	**	22.3%	24.3%	15.2%	16.8%	0.2%	-	**	-	-	-	-	-	-	-	16.8%
	Adult G&A bed occupancy	Jun-25	98.0%	98.3%	94.7%	94.4%	97.6%	95.8%	98.6%	-	84.9%	59.3%	85.4%	89.9%					-	95.8%
	Discharges - Average delay (exclude zero delay) (NEW)	May-25	15.8	**	**	5.9	9.2	7.9	10.1	0.0	5.7	1.5	5.3	0.0						8.8
	Percentage of patients discharged on discharge ready date (NEW)	May-25	89.4%	**	**	89.4%	82.4%	83.8%	91.6%	100.0%	98.0%	87.8%	95.0%	100.0%						88.3%
Planned care	Total incomplete Referral to Treatment (RTT) pathways	May-25	33,721	13,427	36,241	45,691	33,095	68,585	75,064	19,022	5,412	16,106	1,095	14,381			41	-	-	350,979
	The % of people waiting less than 18 weeks on the waiting list (RTT) (NEW)	May-25	47.9%	60.6%	56.5%	63.0%	56.5%	54.3%	64.7%	56.3%	71.1%	50.9%	97.4%	64.0%			100.0%			59.1%
	The % of people waiting more than 52 weeks on the waiting list (RTT) (NEW)	May-25	7.6%	1.0%	4.7%	2.8%	4.6%	4.5%	2.8%	1.8%	1.1%	2.7%	0.0%	0.9%			0.0%			3.7%
	Number of 52+ week RTT waits, of which children under 18 years.	May-25	36	25	182	132	106	39	95	366	0	2	0	0						983
	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	May-25	189	2	326	22	135	581	211	2	8	0	0	3			0	-		1,443
	Patients waiting more than 6 weeks for a diagnostic test	May-25	19.0%	7.2%	19.0%	12.0%	3.7%	7.7%	14.7%	4.9%	1.6%	17.5%	0.0%	0.6%	21.9%	0.0%	-	-	-	12.0%
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Apr-25	80.8%	66.7%	72.8%	76.0%	77.6%	72.5%	80.9%		95.8%	48.9%	83.5%	100.0%	82.4%				-	76.1%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Apr-25	89.7%	98.8%	91.3%	90.1%	98.5%	91.8%	90.1%		100.0%	77.8%	99.6%	100.0%	87.5%				-	94.7%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Apr-25	84.3%	77.5%	75.0%	71.5%	73.7%	75.9%	68.2%		84.2%	74.9%	76.9%	100.0%	89.5%				-	75.4%
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Oct-24	61.7%	63.0%	61.2%	57.4%	58.5%	68.8%	59.7%	-	58.1%	71.3%	41.8%	-	100.0%	-				59.3%
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics ** Indicates that provider did not meet to DQ criteria and is excluded from the analysis # Value supressed due to small numbers ~ No targets set for 2025/26																			

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Learing Disabilities	Inpatients with a learning disability and/or autism (rounded to nearest 5)	May-25	#							#							55	35		**75**
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Apr-25			Mental Health service providers only												77.0%	76.0%	-	77.0%
	CYP Eating Disorders Routine	Apr-25								92%							85.0%	100.0%		92.0%
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact (NEW)	Apr-25				1650				4905					1860		8880	8325	9830	35450
	Number of people accessing specialist Community PMH and MMHS services (NEW)	Apr-25															1250	1330		3620
	Talking Therapies completing a course of treatment - % of LTP trajectory		Just number available/ no target																	102.0%
	Talking Therapies Reliable Recovery	Apr-25															48.0%			48.0%
	Talking Therapies Reliable Improvement	Apr-25															64.0%			67.0%
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Apr-25	82.0%	91.0%	87%	Community Service Providers only									82.0%	89.0%	82.0%	-	79%	86.0%
	Virtual Wards Utilisation ~	May-25	87.7%	82.0%	76.7%	71.7%	72.7%	62.7%	63.2%	85.0%										74.7%
	Community Services Waiting List (Adults)	Mar-24	0	4,540	6,160	420	-	-	447	0	161	-	-	-	3,519	5,378	18,748	3,524	0	42,897
	Community services Waiting List (CYP)	Mar-24	1,268	846	1,527	5,140	-	-	928	5,153	0	-	-	-	4,241	352	891	173	0	20,519
	Community Services – Adults waiting over 52 weeks	Mar-24	0	41	1	0	-	-	0	0	0	-	-	-	43	0	0	10	0	95
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics ** Indicates that provider did not meet to DQ criteria and is excluded from the analysis # Value supressed due to small numbers ~ There is a discrepancy between the data submitted by providers to NHSE and that submitted locally to the ICB - this is being investigated, Data shown here is the nationally published data																			

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Health Inequalities & Improvement	Smoking at Time of Delivery (NEW) data only available at ICB/Place level																			5.9%
Maternity	HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks)	24/25 Q4	0.0	0.0	0.0	1.5	1.7		0.0			0.0								0.5
	Still birth per 1,000 (rolling 12 months)	Mar-25	2.62	1.62	4.74	1.75	2.02	-	2.56	-	-	3.67	-	-						2.95
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation (Healthcare Associated)	12 months to Apr 25	82	25	42	161	82	200	110	15	1	2	14	9						743
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Apr 25	64	31	57	101	88	254	155	16	6	3	26	7						808
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation** #	Jan-25	0.9008	1.1842	0.9370	0.9867	1.0415	0.9669	1.0512											0.997
	Never Events (rolling 12 month total)	12 Months to Jun 25	3	0	1	3	1	2	5	3	1	1	0	3	0	0	0	0	0	23
Workforce / HR (Trust Figures)	Staff in post	May-25	4,510	2,413	5,072	5,897	4,273	14,058	9,753	4,219	1,919	1,726	1,900	1,498	1,378	1,472	10,533	3,852	-	74,472
	Bank	May-25	295	193	367	347	360	1,027	741	99	59	85	16	75	22	41	1,186	185	-	5,098
	Agency	May-25	22	45	78	25	32	120	129	5	5	6	9	6	3	3	95	43	-	624
	Turnover	Mar-25	12.2%	10.4%	9.0%	9.9%	12.3%	10.3%	9.4%	9.1%	10.5%	9.5%	8.9%	12.0%	10.6%	10.6%	12.0%	10.6%	-	10.4%
	Sickness (via Ops Plan Monitoring Dashboard)	Mar-25	5.9%	5.5%	5.1%	6.0%	6.0%	6.1%	6.0%	5.5%	5.1%	5.8%	4.8%	5.6%	6.4%	6.3%	7.6%	6.1%	-	6.1%
Finance	Overall Financial position **Variance** (£m)	May-25	-2.63	-0.32	-0.38	-29.40	0.00	-2.32	0.00	-0.87	-0.06	0.03	0.31	-3.94	-3.82	-9.42	0.00	0.22	-47.25	-94.50
	Efficiencies (Variance)	May-25	-6.55	-0.00	-3.32	-4.70	0.62	-7.66	-0.00	1.15	-1.73	0.66	-0.00	-1.02	-2.02	-0.00	0.00	-1.15	-23.39	-46.78
	Capital (Variance)	May-25	13.18	0.76	-18.64	0.00	-0.43	1.87	0.10	-0.02	0.81	2.36	1.09	2.12	2.10	0.36	7.27	2.47	24.57	49.13
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics ** The SHMI banding gives an indication for each non-specialist trust on whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, was as expected when compared to the national baseline, as the UCL and LCL vary from trusts to trust. This "banding" is different to the "rate" used for the ICB on slide 5, therefore a comparison cannot be drawn between the two. # Banding changed Aug 23 to reflect SOF rating by NHSE. 'As expected' rating is RAG rated Green, 'Higher than expected' is RAG rated Red.																			

4. Place Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Urgent Care	4-hour A&E waiting time % waiting less than 4 hours	Jun-25	54.3%	61.9%	27.8%#	54.3%	74.7%	56.7%	76.5%	65.9%	63.7%		73.0%	73.5%	78% by Year end
	Ambulance category 2 mean response time	Jun-25	00:30:58		00:30:46	00:29:04	00:28:57	00:30:36	00:29:37	00:31:24	00:31:30		00:30:22		00:30:00
	A&E 12 hour waits from arrival	Jun-25	$	$	20.3%	22.8%	12.1%	21.1%	15.1%	23.6%	12.7%		16.8%	16.4%	-
	Discharges - Average delay (exclude zero delay) (NEW)	May-25	7.0	14.4	5.7	8.2	8.7	14.8	7.6	11.2	6.5		8.8	9.3	
	Percentage of patients discharged on discharge ready date (NEW)	May-25	90.5%	90.2%	89.9%	83.1%	83.6%	95.9%	94.2%	92.1%	84.2%		88.3%	85%	
Planned Care	Total incomplete Referral to Treatment (RTT) pathways	May-25	103,817		50,371	27,614	58,696	28,612	22,882	20,444	38,543		350,979	361,635	-
	The % of people waiting less than 18 weeks on the waiting list (RTT) (NEW)	May-25	56.0%		62.7%	59.2%	56.4%	65.1%	60.4%	59.1%	56.9%	67.0%	59.1%	58.0%	
	The % of people waiting more than 52 weeks on the waiting list (RTT) (NEW)	May-25	4.5%		2.9%	4.3%	3.6%	2.6%	3.5%	3.7%	3.3%		3.7%	3.2%	
	Patients waiting more than 6 weeks for a diagnostic test	May-25	15.8%		11.4%	4.7%	7.3%	18.1%	15.0%	14.7%	9.0%		12.0%	5.0%	5%
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Apr-25	70.3%	77.9%	77.2%	77.8%	74.3%	88.9%	78.7%	83.1%	67.1%		76.1%	72.3%	85.0%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Apr-25	94.4%	90.2%	95.1%	95.0%	94.6%	96.2%	95.9%	96.3%	92.6%		94.7%	96.0%	96.0%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Apr-25	75.9%	80.9%	70.9%	75.3%	75.5%	80.4%	78.2%	78.0%	66.6%		75.4%	77.0%	77% by Year end
Mental Health	Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Apr-25	4,045		2,605	1,455	6,560	1,095	1,900	1,040	3,580		22040		
	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Apr-25	78.0%		77.0%	67.0%	73.0%	64.0%	91.0%	86.0%	90.0%	100.0%	77.0%	60.0%	60.0%
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	To Mar 2025	59.0%		62.0%	70.0%	63.0%	56.0%	68.0%	70.0%	51.0%	68.0%	62.0%	-	60.0%
	Dementia Diagnosis Rate	May-25	67.2%		66.2%	72.4%	68.5%	66.0%	64.8%	67.1%	68.16%		67.6%	66.7%	66.7%
	CYP Eating Disorders Routine	Apr-25	100.0%		100.0%	100.0%	83.0%	94.0%	93.0%	78.0%	94.0%	100.0%	92.0%	95.0%	95.0%
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact (NEW)	Apr-25	6015		4700	4055	8465	4175	2630	1710	2325	1500	35450	37246	-
	Number of people accessing specialist Community PMH and MMHS services (NEW)	Apr-25	1045		395	320	720	280	280	180	240	155	3620	3420	-
	Talking Therapies completing a course of treatment	Apr-25	725		390	185	595	225	145	105	170	100	102.0%	100.0%	100.0%
	Talking Therapies Reliable Recovery	Apr-25	50.0%		45.0%	50.0%	48.0%	49.0%	47.0%	46.0%	48.0%	52.0%	48.0%	48.0%	48.0%
	Talking Therapies Reliable Improvement	Apr-25	68.0%		70.0%	69.0%	65.0%	67.0%	64.0%	60.0%	68.0%	71.0%	67.0%	67.0%	67.0%
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. # Potential data issue at Wirral Cummunity Health which recorded no patients seen within 4-hours $ East Cheshire and Mid Cheshire provider did not meet to DQ criteria and is excluded from the analysis														

4. Place Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Sub ICB Place									ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside							
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton			
			East **	West **							South Sefton	S/port & Formby		
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Apr-25	20		10	5	15	5	10	10	5		80	50	-
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Apr 25 YTD	3.2%		2.3%	2.1%	4.0%	1.6%	2.9%	3.7%	3.4%		3.1%	3.3%	**75%** by Year end
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Mar-25	88.0%	82.0%	90.0%	83.0%	78.0%	83.0%	92.0%	100.0%	79.0%		85.0%	70.0%	**70.0%**
	Virtual Wards Utilisation Number only	May-25	70	82	39	24	58	40	8	15	14		351		
	Community Services Waiting List (Adults) - data only available at ICB/Provider level												42,897		
	Community services Waiting List (CYP) - data only available at ICB/Provider level												20,519		
	Community Services – Adults waiting over 52 weeks - data only available at ICB/Provider level												95		
Primary Care	Appointments in General Practice & Primary Care networks (NEW)@	Apr-25	191539	168088	199098	103850	240983	81855	77743	53866	120546		1237568	1294229	
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Mar-25	5.92%	7.25%	9.12%	6.21%	7.28%	5.91%	6.59%	6.20%	7.70%		7.09%	10.0%	**10.0%**
	Total volume of antibiotic prescribing in primary care	Mar-25	0.81	0.90	1.05	0.88	0.97	1.15	1.13	1.01	1.00		0.97	0.871	**0.871**
Integrated care - BCF metrics ***	Unplanned hospitalisation for chronic ambulatory care sensitive conditions ***	Q3 24/25	195.9	219.7	165.8	187.0	272.5	277.8	312.3	254.8	171.3		228.6	-	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Mar-25	88.9%	90.6%	94.4%	95.1%	95.5%	94.6%	94.5%	95.5%	92.6%		93.3%	-	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 ***	Q3 24/25	552.8	547.7	329.8	383.4	751.0	550.2	772.2	494.1	501.4		542.5	-	-
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6,7 and 8 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. *** Awaiting clarification from NHSE re: metric criteria. Plans are no longer comparable to actuals largely due to implementation of SDEC (Type 5) in year but also revisions to National crtieria which systems need time to adopt and validate. ~ Wirral and Warrington have reported figures less than half the previous quarter @ RAG based on last year postion, Green for greater than last year														

4. Place Aggregate Position

NHS Cheshire and Merseyside

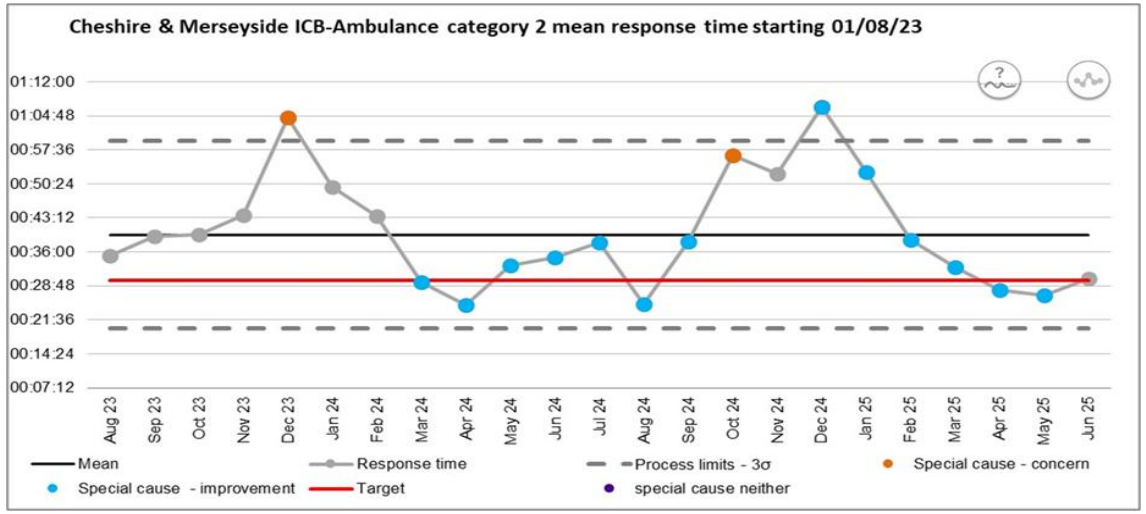
Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q3 24/25	66.6%		63.5%	64.7%	66.4%	65.4%	64.5%	68.2%	63.6%		65.5%	77.0%	80.0%
	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with lipid lowering therapies	Q3 24/25	61.8%		65.3%	61.0%	64.7%	62.0%	63.7%	62.1%	60.2%		62.6%		65%
	Smoking at Time of Delivery	Q4 24/25	4.3%		6.8%	4.9%	5.3%	8.9%	7.3%	8.8%	6.7%		5.9%		<6%
	Smoking prevalence - As per GP systems	Feb-25	10.98%	11.87%	13.69%	9.51%	16.06%	13.08%	16.47%	16.95%	13.12%		13.4%	12%	12%
Continuing Healthcare	Standard Referrals completed within 28 days	Q4 24/25	74.4%		75.8%	85.3%	63.0%	92.9%	96.4%	82.1%	78.3%	68.2%	76.00%	>80%	>80%
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q4 24/25	21.56		25.96	16.61	22.39	39.89	11.09	26.73	53.34	72.01	27.04	<18	
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q4 24/25	62.6		75.2	42.7	45.6	32.8	31.1	42.9	61.1	81.4	54.67	<34	
Quality & Safety	Still birth per 1,000 - data only available at ICB/Provider level														
	Healthcare Acquired Infections: Clostridium Difficile - (Healthcare & Community associated) (NEW)	12 months to Apr 25	287		243	94	215	53	95	63	105		1155	843	-
	Healthcare Acquired Infections: E.Coli - (Healthcare & Community associated) (NEW)	12 months to Apr 25	655		279	201	454	183	219	112	227		2330	2001	
Finance	Overall Financial position Variance (£m)	May-25	0.7	0.5	-0.8	0.3	-0.8	-0.3	0.2	-0.1	0.2		0.1	0.0	0.0
	Efficiencies (Variance)	May-25	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	0.0	0.0
	Mental Health Investment Standard met/not met (MHIS)	May-25	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Yes	Yes
	BCF achievement (Places achieving expenditure target)	May-25	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	9/9	9/9
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6,7 and 8 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. *** Local trajectories set by Place as part of their BCF submissions to NHSE, therefore RAG rating will vary for Places with lower/higher trajectories **** In order to report performance at Place the indicator "% of CYP accessing services following a referral" has been used - this is different to the NHS Oversight Framework indicator used in the ICB table														

5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

Ambulance category 2 mean response time

Latest ICB Performance (June-25)	00:30:22	National Ranking	22/42
ICB Trend (June-25)			Deteriorated



Issue

- There has been a sight deterioration in Category 2 mean ambulance response time for June, reversing recent positive trends

Action

- NHS England issued formal notification to all North West systems (17 June) confirming the go-live of the 45-minute maximum handover standard from 1 August 2025.
- All acute providers are working jointly with NWAS and SCC to ensure: Implementation of patient safety checklists, consistent use of Fit2Sit and clear understanding and application of local escalation protocols.
- Aintree conducted a 3-day test of the 45-minute handover model and has disseminated learning across the system.
- Ongoing testing includes: Localised action cards, Continuous flow protocols and therapy pathway reviews to reduce delays at the front door.
- Cheshire and Merseyside will initiate a soft launch of the Handover 45 (HO45) protocol from 28 July ahead of full implementation on 1 August.

Delivery and Impact

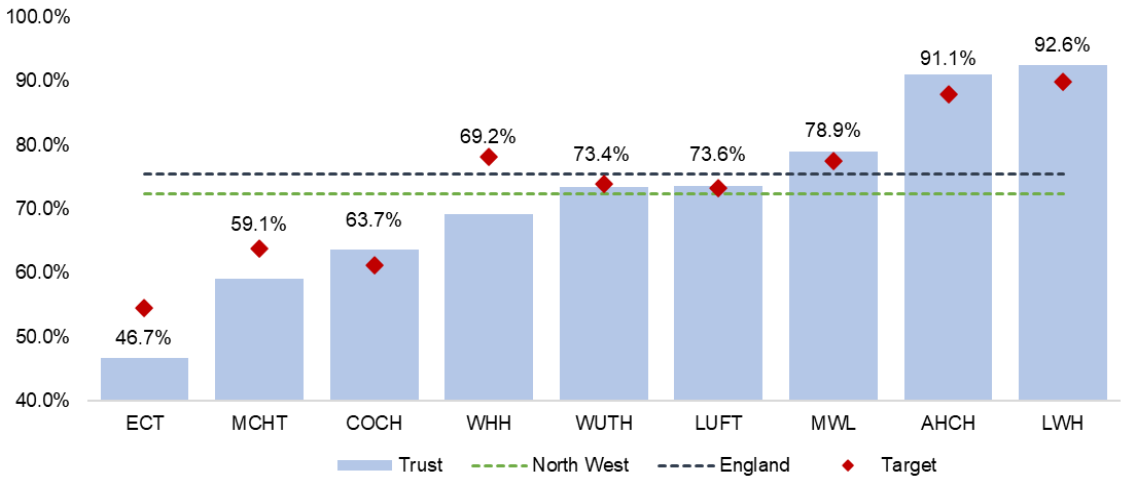
- The nationally mandated OPEL framework has been embedded into SCC's daily operational oversight, with average ambulance handover time monitored from midnight as a key improvement indicator.
- Enhanced governance through the Ambulance Improvement Group supports delivery of the 45-minute threshold.
- These system-wide interventions are expected to drive further improvements in Category 2 ambulance response performance.

5. Exception Report – Urgent Care

Cheshire and Merseyside

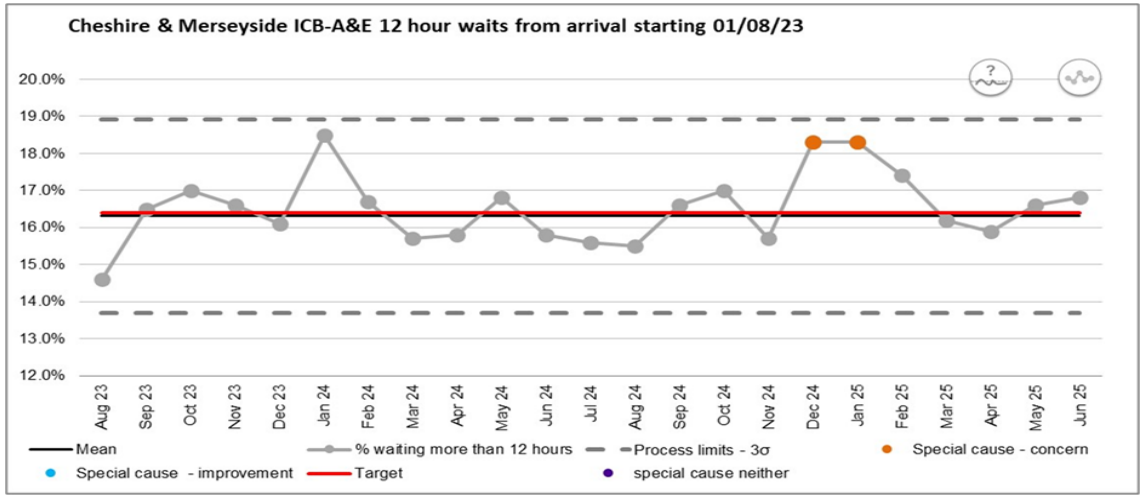
A&E 4 hour waits from arrival

Latest ICB Performance (June-25)	73.0%	National Ranking	29/42
Provider Breakdown (June-25)			Deteriorated



A&E 12 hour waits from arrival

Latest ICB Performance (June-25)	16.8%	National Ranking	40/42
ICB Trend (June-25)			Deteriorated



Issue

- C&M performance in June was 73.0%, which is 4.3% below the national ambition of 78%. Despite an improvement on the previous month, this places the ICB 29th out of 42 nationally. However, 16.8% of patients experienced 12-hour delays from time of arrival, marking a deterioration on the previous month and placing the system 40th out of 42 nationally.

Action

- **MWL:** Monitoring application of ECIST criteria to admit, supporting early decision-making, embedding discharge tracking tools and implementing the 12-hour guardian role. MWL has exceeded the 78% threshold for 4-hour performance, but 12-hour delays remain at 16.5%.
- **East Cheshire:** GP front door redirection test (May 2025) showed 69% of patients diverted from ED. Despite a 2.1% dip in May, a longer-term trend of improvement is noted. Reviewing senior initial front-end triage (SIFT) for continued implementation.
- **Liverpool:** Improvements to specialty pathways (e.g. frailty) support reduced ED LOS. 12-hour performance improved to 17.4% in June, despite underlying system pressure.
- **Wirral:** Enhanced Call Before Convey activity supported by UCR in-reach to ED and Frailty SDEC. 4-hour performance remains challenged at 71.7%, with lower-than-expected call before convey utilisation.
- **Warrington:** ECIST review highlighted ED workforce deficits and informed a revised resourcing plan. Testing underway on Palliative and End of Life triage and virtual ward admission from ED.

Delivery

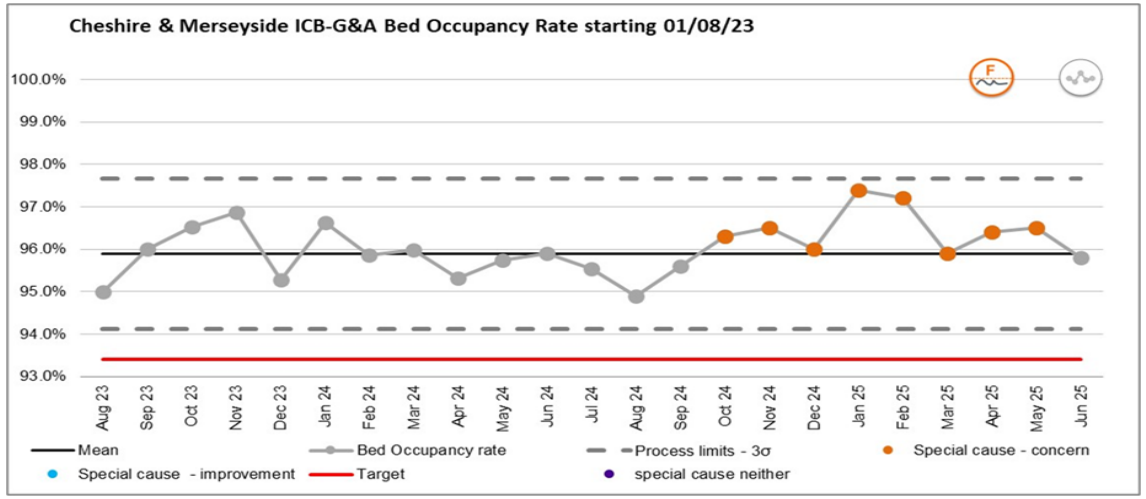
- Cheshire and Merseyside continue to adopt a recovery-focused model for urgent and emergency care in 2025/26. A range of targeted initiatives—particularly around front-door streaming, frailty, discharge support, and ED workforce optimisation—are being implemented to achieve the 78% national standard and reduce 12-hour breaches. The system remains committed to delivering sustained improvements, in line with national expectations for Q3 performance.

5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

Adult G&A bed occupancy

Latest ICB Performance (June-25)	95.8%	National Ranking	32/42
ICB Trend (June-25)			Improved



Issue

- Bed occupancy remains consistently high across the system, with June levels at 95.8%. While there has been marginal improvement, this level of occupancy continues to exert significant operational pressure, impacting both patient flow and hospital resilience.

Action

- **Warrington:** The Older People's Short Stay Unit (OPSSU) has been established to reduce length of stay for patients aged 65+, with board round audits in progress to inform future action plans.
- **Wirral:** Therapy-led pathway review underway to reduce delays for patients not meeting criteria to reside (NCTR). Earlier involvement of Care Transfer Hubs is being implemented to address discharge delays related to housing and social care.
- **UHLG:** Discharge tracking tools (EDD) are in place to support improved management of Pathway Zero patients, with targeted reductions in corridor care at Royal Liverpool.
- **East Cheshire:** A 7-day multi-disciplinary discharge sprint is ongoing across medical, diagnostic, and therapy teams. Bed occupancy has risen to 95.1% in June, compared to a local mean of 93.7%.
- **MWL:** Expected discharge dates & patient flow are being actively monitored for Pathway Zero patients.

Delivery

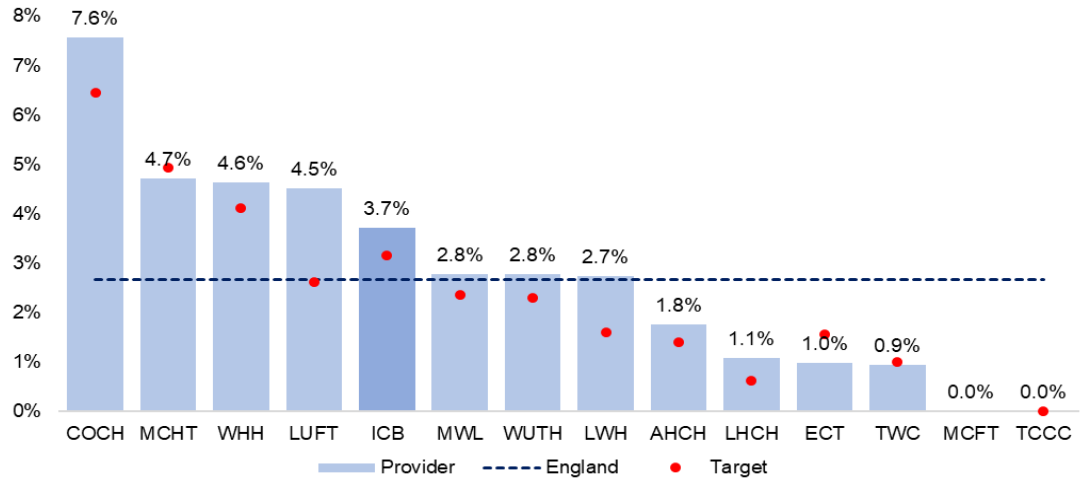
- In alignment with the 2025/26 recovery trajectory for urgent and emergency care, the ICB continues to prioritise the reduction of adult G&A bed occupancy as a key system-wide performance metric.
- Ongoing interventions are expected to further reduce occupancy levels while supporting sustainable discharge processes and operational efficiency.

5. Exception Report – Planned Care

NHS Cheshire and Merseyside

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

Latest ICB Performance (May-25)	3.7%	National Ranking	38/42
ICB Trend (May-25)			Deteriorated



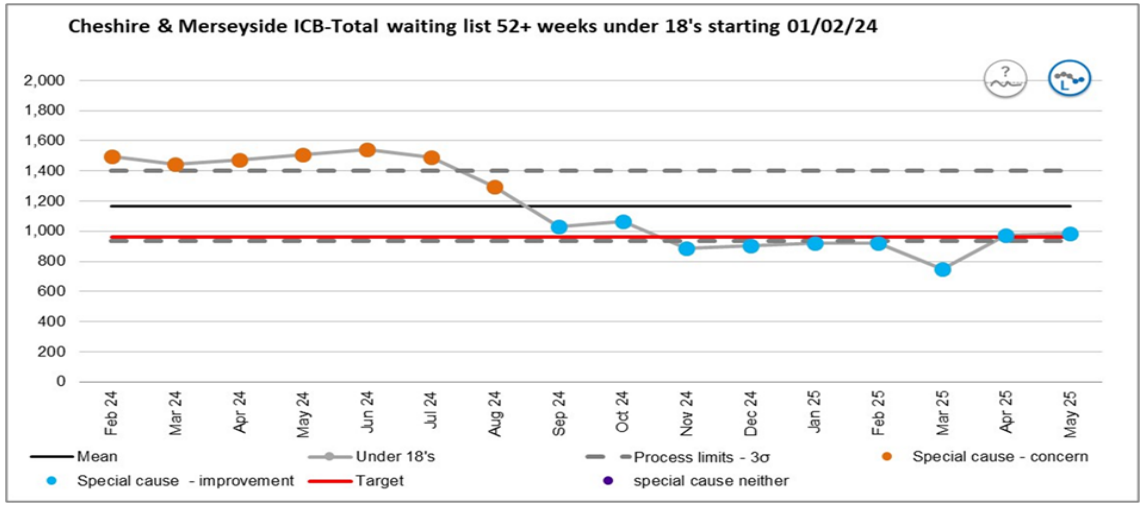
Issue
- The system has several organisations who are off plan in relation to their 52 week-long waits position. There are 14,520 patients waiting over 52 weeks.
- There are 2 trusts who are deploying new trust-wide EPR systems and are in the infancy of transition. In some of the bigger trusts there are more enhanced and detailed recovery plans in place.

Action
- The elective reform team have fortnightly calls with all providers to review their plan vs actual position. This ensures that specific recovery actions are managed and overseen with system support in place when required
- Managing long waits across some of our key specialities at system level continues to be a challenge – ENT particularly has 2,992 pathways waiting over 52 weeks.
- Improvement and transformation programme covering T&O, ENT and Gynaecology have been initiated by the Elective Reform Programme.
- Increasing the use of A&G, PIFU and going further with Validation will have significant impact on the Trusts ability to manage the demand and decrease waits.
- Additional capacity is being considered by all organisations who are currently off plan.
- The system financial position has impacted the ability to continue to use insourcing and outsourcing at some organisations for some of the highly challenged specialities.
- Targeted delivery of the 65ww target will support improvement in 52ww position.

Delivery
- There is a continued focus on eradicating 52 week waits and this remains a key critical priority in order to meet our target for March 2026.

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

Latest ICB Performance (May-25)	983	National Ranking	n/a
ICB Trend (May-25)			Deteriorated



Issue
- The system has several organisations who are off plan in relation to their 52 week-long waits position. There are 1,183 CYP patients waiting 52 weeks.

Action
- The elective reform team have monthly meetings with all Cheshire & Merseyside providers to review their plan vs actual position, to ensure specific recovery actions are managed and overseen with system support in place when required.
- Managing long waits across some of our key specialties at system level continues to be challenged, with all providers reporting challenges within ENT and Dental pathways.
- Significant improvement in the current waiting position were delivered in FY 24/25 with a continued focus in 25/26.

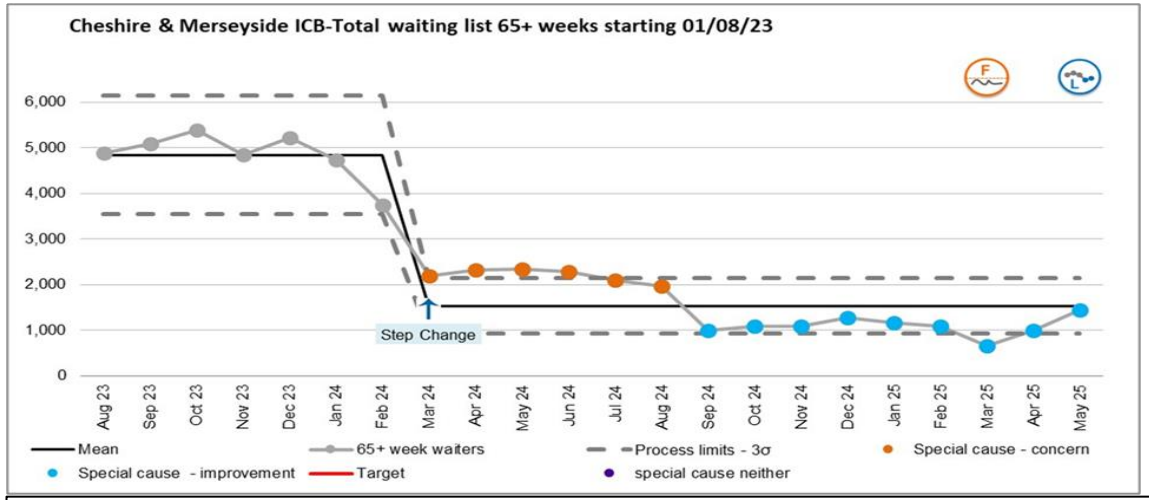
Delivery
- There is a continued focus on eradicating 52-week waits and this remains a key critical priority in order to meet our target for March 2026.

5. Exception Report – Planned Care

Cheshire and Merseyside

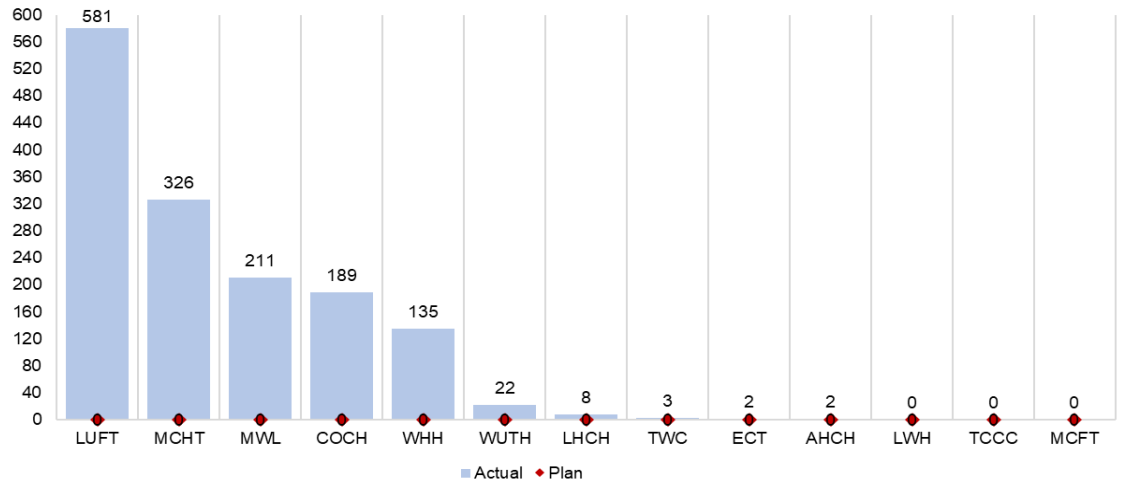
ICB incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (May-25)	1,443	National Ranking	n/a
ICB Trend (May-25)			Deteriorated



Trust incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (May-25)	1,443	National Ranking	n/a
Provider Breakdown (May-25)			Deteriorated



Issue

- Challenges remain in clearing 65 week wait patients, excluding patient choice and complexity issues with 7 providers reporting capacity breaches at July month end.
- Local data shows 921 patients reported 65-week breaches at end of July with 639 being capacity breaches, 149 complex patients and 119 choice related delays and 14 corneal grafts.. The breaches largely sit within Mid Cheshire and LUFT who continue to report an increased position.

Action

- The elective programme is working closely with providers to ensure that mutual aid and operational tactical measures are explored and expedited. Active mutual aid is being supported for Mid Cheshire in relation to T&O. LUFT are receiving ENT support.
- CMPC have initiated 90-day improvement plans covering ENT, Gynae, Theatre Productivity and are steering organisations into improved practice around PIFU and A&G Utilisation
- A new meeting structure has been established to steer performance output on the delivery of 65 weeks and there is good indication that the systems 65-week position will improve by July & August. There are clear actions being taken by organisations and these are being overseen by the Elective Reform Team.
- Extra ordinary 65week delivery call has been set up and chaired by the Elective Reform SRO (Janelle Holmes), which takes place on a weekly basis, the meetings objective is to ensure providers deliver a zero position by end of Aug 2025. there will be direct communications between CMPC and the provider CEO's for any organisations falling below the required expectations.
- CMPC continues to prioritise validation activity with current performance reporting at 12-weeks 67.47%, 26-weeks 74.26% and 52-weeks 77.16%, with 8 providers reporting above the national ambition of 90% (no submission from ECHT & MCHT due to implementation of new EPR system).
- At MCHT, there are significant pressures within several specialties and CMPC continues to offer support in relation to mutual aid, MSK, triage, additional valuation support and sharing best practice pathways.

Delivery

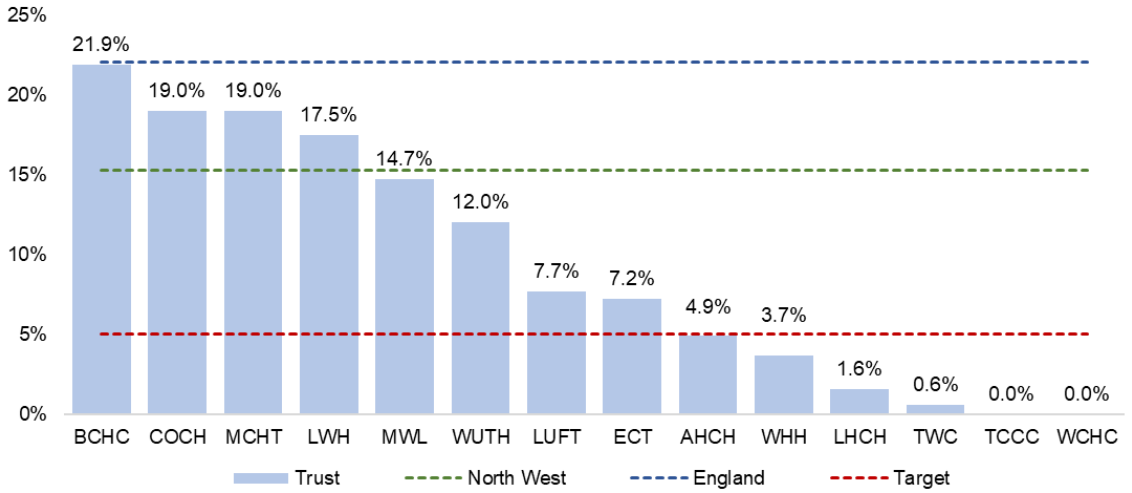
- There is a continued focus on eradicating 65 week waits and to model the delivery of 52 and 18 weeks for future planning.
- CMPC continues to report into region on current performance and plans for immediate recovery.

5. Exception Report – Diagnostics

NHS Cheshire and Merseyside

Patients waiting more than 6 weeks for a diagnostic test

Latest ICB Performance (May-25)	12.0%	National Ranking	3/42
Provider Breakdown (May-25)			Deteriorated



Issue
- C&M performance has deteriorated since April, for reasons including financial constraints reducing any waiting list initiatives and other premium rate activity such as outsourcing and insourcing.
- C&M remain in the top 5 ICS for Diagnostic performance (since January 2024) and have maintained a ranking of 3rd this month.

Action
- Mutual Aid Process – refreshed support for the process with Trust COO's
- System capacity continues to be maximised through CDCs and the Mutual Aid Process, however, capacity in some tests is unable to meet the increase in demand, specifically NOUS & ECHO.
- Imaging Network deep dive into NOUS capacity across the system to be performed with a focus on MSK NOUS.
- PTLs with Trusts continue to support plans for improved performance.

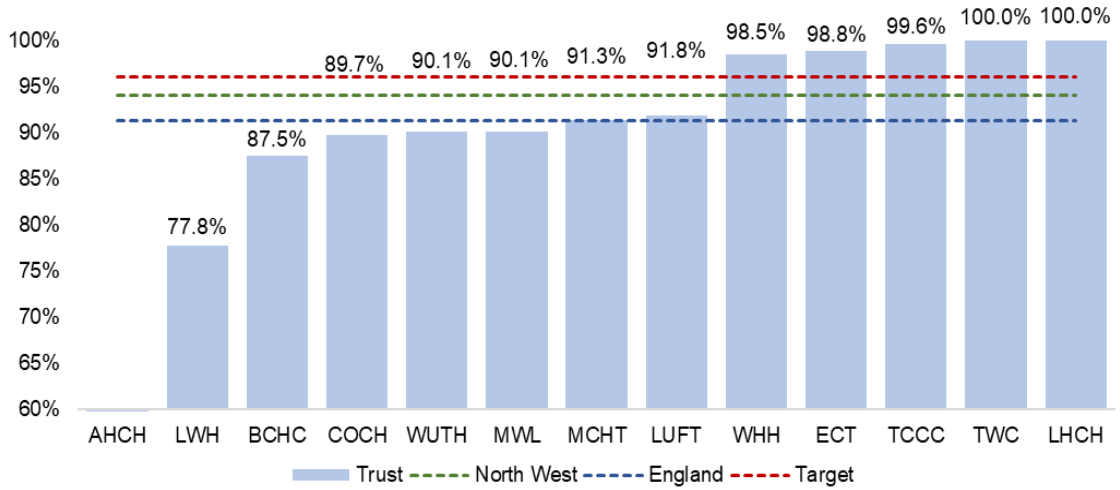
Delivery
- No national diagnostic performance target set by NHSE for 25/26. However, the NHS constitutional standard remains at 99% and timely access to diagnostics is a key enabler for the achievement of RTT and cancer treatment targets
- The Diagnostic Programme is well linked with the C&M Cancer Alliance and Elective Recovery Team to resolve delays in pathways associated with delays to accessing a diagnostic test.

5. Exception Report – Cancer

NHS Cheshire and Merseyside

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

Latest ICB Performance (Apr-25)	94.7%	National Ranking	11/42
Provider Breakdown (Apr-25)			Deteriorated



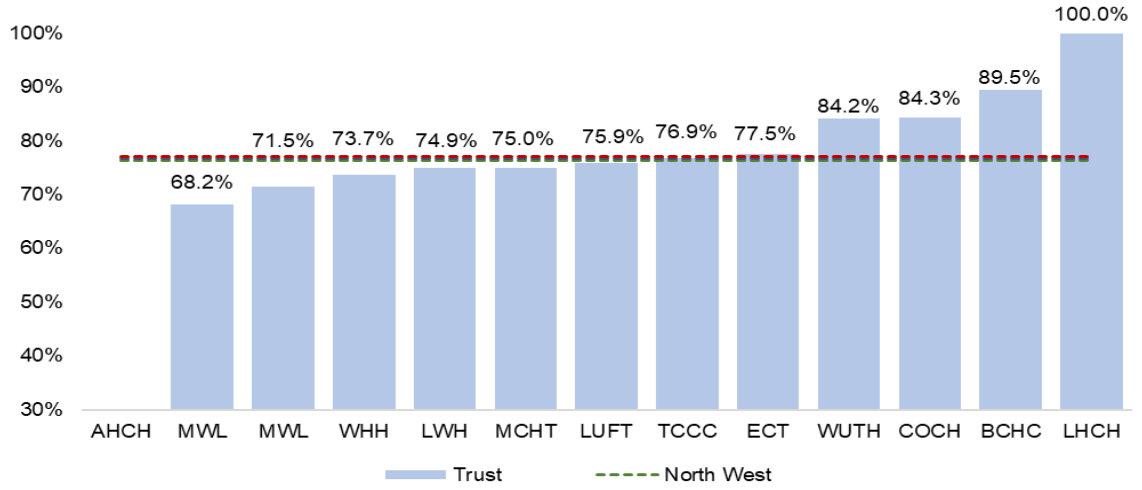
Issue
- C&M not yet achieving the 96% 31-day combined standard required. However, the figure of 94.7% is 7th amongst Cancer Alliances and 11th amongst ICBs. It should be noted that this figure is 3.4% points ahead of England and represents very good performance for C&M.

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

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

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

Latest ICB Performance (Apr-25)	75.4%	National Ranking	31/42
Provider Breakdown (Apr-25)			Deteriorated



Issue
- C&M Faster Diagnosis Standard (FDS) performance remains below the operational standard (77%, rising to 80% by March 26).

Action
- CMCA has produced bespoke improvement trajectories for each provider which are linked to improvement plans managed via the CMCA performance forum.
- The Pathways Improvement Programme continues to work across the nationally mandated priority tumour sites, implementing 'in depth reviews' to assess underlying performance drivers for cancer pathways (LGI, Breast, Skin, Gynae, Urology).
- A range of cross-cutting initiatives are underway such as an MDT bank, CDC optimisation group and single-queue diagnostic work.

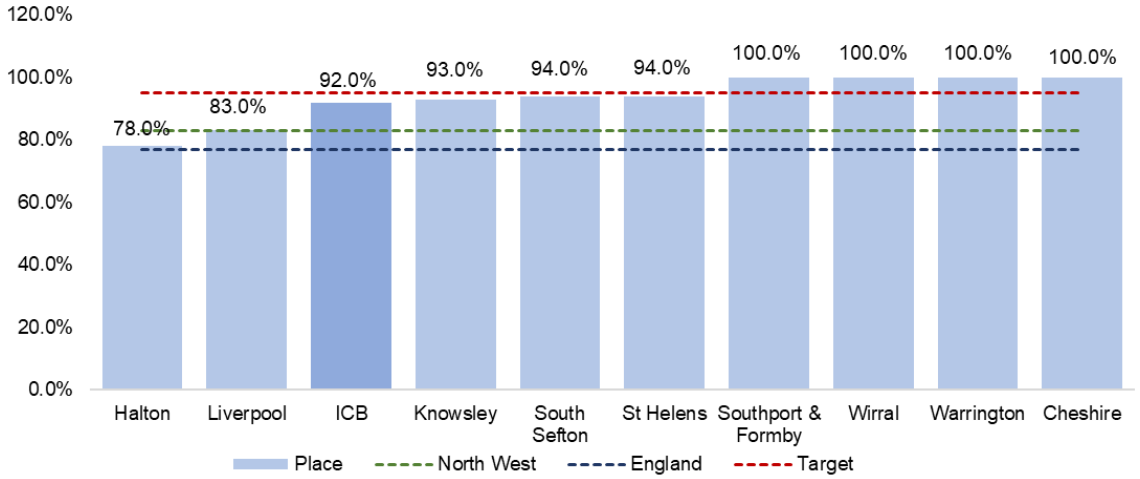
Delivery
- C&M is still expecting to meet the 80% ambition by the end of the financial year 25/26.

5. Exception Report – Mental Health

NHS Cheshire and Merseyside

CYP Eating Disorders Routine

Latest ICB Performance (Apr-25)	92.0%	National Ranking	5/42
Place Breakdown (Apr-25)			Improved



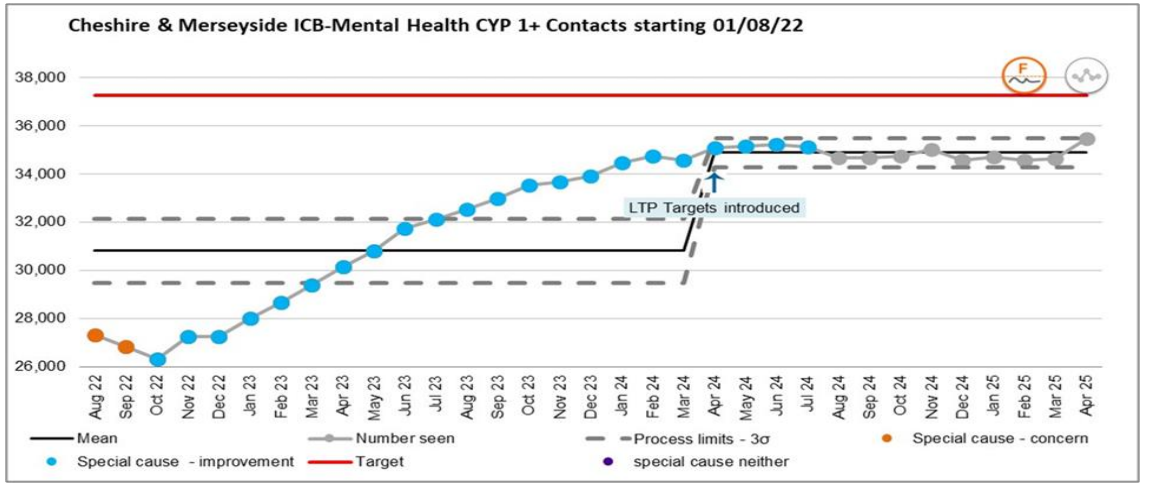
Issue
- National data indicates a 6% improvement in performance between Mar and Apr 25, however, the nationally reported position remains below the routine waiting time standard of 95% seen within 4 weeks.
- Data quality issues still exist in the MHSDS at Alder Hey and Mersey Care.

Action
- During the last 6 months, Alder Hey has been re-writing the MHSDS process to improve accuracy and reporting.
- MCFT have developed local 'live' reports to track the MHSDS data set.
- Work is also underway to review how pathways can be improved across community eating disorder teams to provide more effective and efficient care.

Delivery
- Alder Hey nationally reported data has improved from 78% in Mar to 92% in Apr 25.
- CWP continues to achieve 100% of patients seen within 4 weeks.
- Mersey Care nationally reported data at 85%.

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

Latest ICB Performance (Apr-25)	35,450	National Ranking	n/a
ICB Trend (Apr-25)			Improved



Issue
- Access has been consistently below target by circa 3,000 CYP during 2024/25 (92% - 94% of LTP trajectory).
- Not all VCSE services are able to flow data to the national dataset so this activity is not captured in its totality.

Action
- Roll out of 5 new wave 11 MH in school teams will support increased access over the coming months (Liverpool, South Sefton, Cheshire, Wirral & Knowsley).
- C&M CYP Access Development Workstream reviewing trajectories at sub-ICB level to identify actions to address continued downward trends in Cheshire, Knowsley and Wirral which are masking improvement in other places.

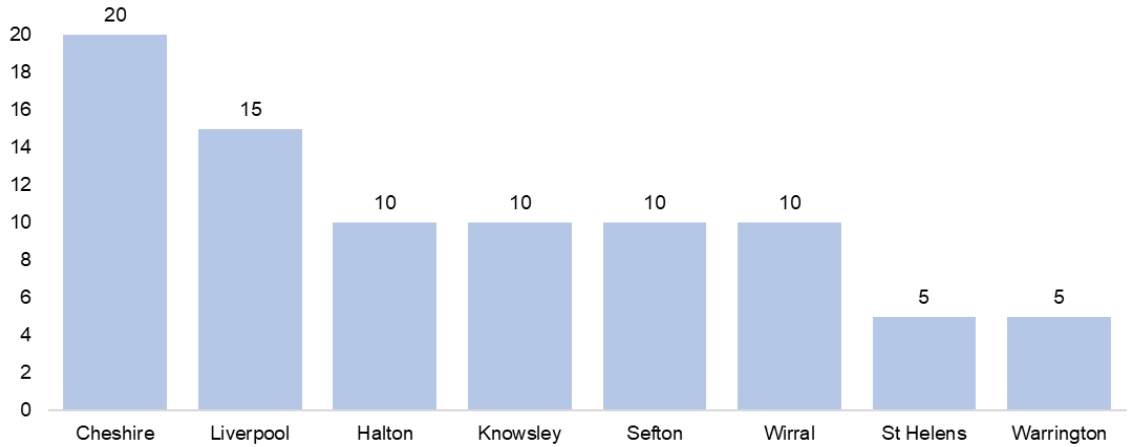
Delivery
- There has been no significant change in overall C&M access rates during 2024, however there is more significant variance in place level trends.
- Downward trends from Apr 24 in 3 places. Cheshire is having the most significant impact with a reduction of 1,795 between Apr 24 and Apr 25. This is partially due to the re-procurement of the contract for the Emotionally Healthy Schools (EHS) service in East Cheshire with data no longer contributing to CYP access from Apr 24.

5. Exception Report – Learning Disabilities

NHS Cheshire and Merseyside

Adult inpatients with a learning disability and/or autism

Latest ICB Performance (May-25)	75 *	National Ranking	22/42
Place Breakdown * (Apr-25 - *1 month lag*)			Improved



Issue
- There were 75 adult inpatients, of which 47 are Specialised Commissioning (Spec Comm) inpatients commissioned by NHSE, and 28 ICB commissioned. The target identified for C&M (ICB and Spec Comm) is 46 LD/A or fewer by the end of Q4 2026 and 28 Autism only.

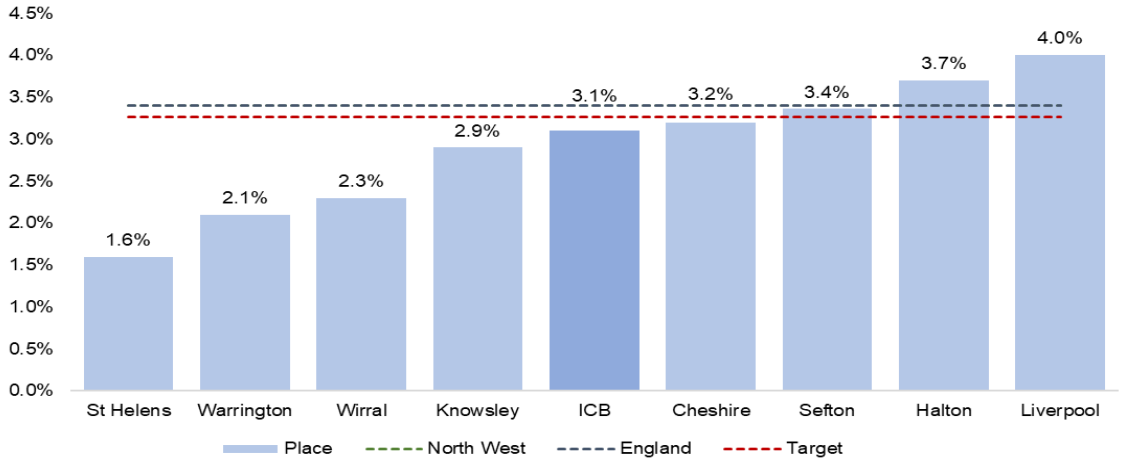
Action
- The Transforming Care Partnership (TCP) has scrutinised those clinically ready for discharge. Of those 75 adults, 10 individuals are currently on Section 17 Leave. It is expected that some of the existing section 17 leave individuals will be discharged in Q1 pending MOJ Clearance and transition progress. We have identified 33 people for discharge during 25/26 of this cohort.
- Data quality checks continue to be completed on Assuring Transformation to ensure accuracy.
- 2-weekly C&M system calls ongoing to address Delayed Discharges with Mersey Care and CWP.
- Housing Lead continues to work to find voids which can accommodate delayed discharges.
- Desktop reviews take place to address section 17 leave progress and those identified for discharge.
- Adult Autism only MaDe calls set up monthly to address all admissions to adult MH wards.

Delivery
- C&M ICB and NHSE aim to reduce the number of inpatients, where appropriate, by the end of Q4 2025/26, where the target is 46 for LD/A and 28 for people with Autism.

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

Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register

Latest ICB Performance (Apr-25)	3.1%	National Ranking	29/42
Place Breakdown * (Apr-25)			NEW



Issue
- C&M have not achieved the planned trajectory for April; however it is not unusual for this to occur during the first quarter, as health check activity typically increases over the course of the financial year.

Action
- Continue to work at Place to oversee AHC delivery.
- Establish the quality of AHC.
- Ensure the LD Register in GP practices are up to date and data cleansed .
- Monitor non-attendance to AHC.
- Align to the learning from LeDeR and implement to avoid recurrence of poor practice across Primary and Secondary Care.

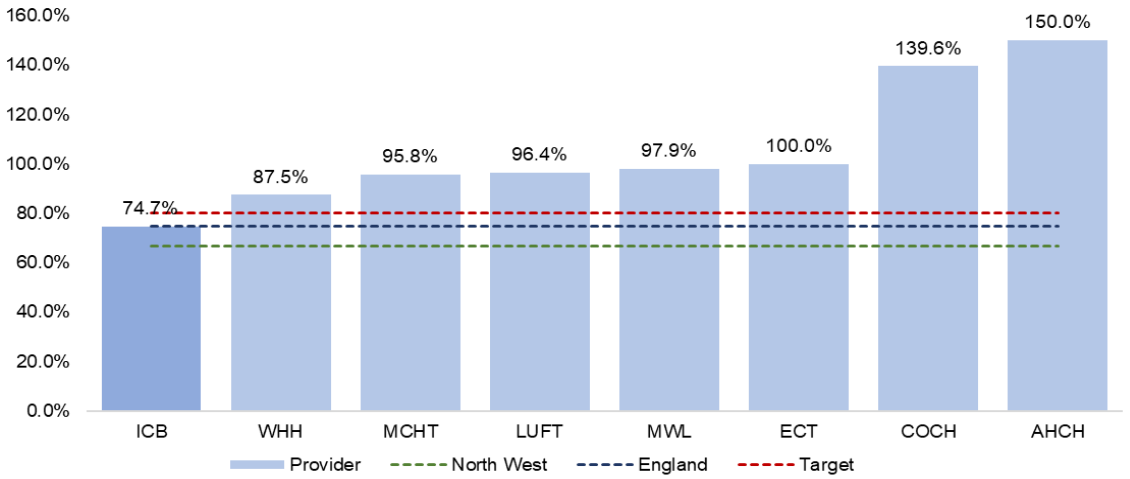
Delivery
- To achieve the Q1 target of Annual Health Checks within C&M
- Achievement of 75% compliance of AHC by Q4 25/26 is still anticipated.

5. Exception Report – Community

NHS Cheshire and Merseyside

Virtual Wards Utilisation

Latest ICB Performance (May-25)	74.7%	National Ranking	20/42
Provider breakdown (May-25)			Deteriorated



Issue

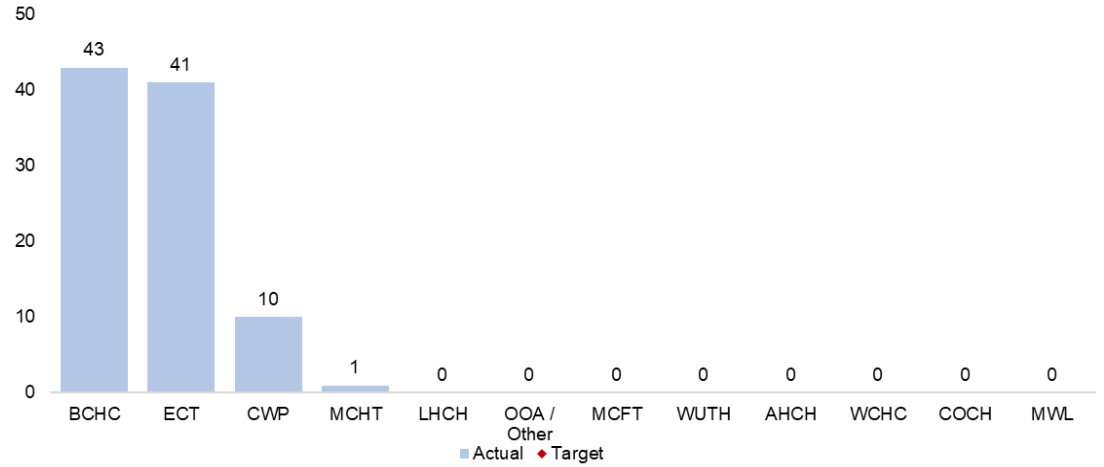
- The May 2025 performance shows a discrepancy in utilisation data. While individual Lead Providers appear to exceed the 80% utilisation target, the average across Cheshire & Merseyside (C&M) Lead Providers is only 74.7%, falling below the agreed threshold. In addition, there is an absence of data regarding VW provided by WUTH.
- It is likely that the data discrepancies arise in part from differences in the dates and figures used in the data submissions as well as other factors that are being reviewed. The data discrepancy shows a worse picture for C&M in external data flows than is believed to be accurate.
- The national data is published based on the final sitrep data submission by providers in the calendar month, while the local data may cover different periods. Specifically, the national data for May 2025 was taken from the last sitrep submission on 30th May 2025, whereas the local data was from 25th May 2025.
- There are also recognised discrepancies due to providers submitting varying bed capacity figures that reflect beds available that day rather than the commissioned number of beds for that provider.
- These 2 known issues alone do not fully explain the misalignment of data and further work is being taken forward by the programme team

Actions

- Await response to clarify the source and resolve the discrepancy.

Community Services – Adults waiting over 52 weeks

Latest ICB Performance (Apr-25)	95	National Ranking	n/a
Provider breakdown (Apr-25)			Improved



Issue

- ECT continue to experience long waits related predominantly to their dietetics and Speech and Language Therapy services where there recognised issues with referral management and capacity that are being addressed. It is unlikely however that a significant improvement will be seen within the next 3- 6 months
- CWP previously identified an inaccuracy in the reporting of long wait patients that has now been addressed and is reflected in this reporting period.
- BCHC waits are primarily within the Adult podiatry service and a capacity and demand review is in progress to address this issue.

Action

- Capacity and demand review of podiatry service at BCHC.
- Review of inappropriate referrals to SALT and dietetics service at ECT.

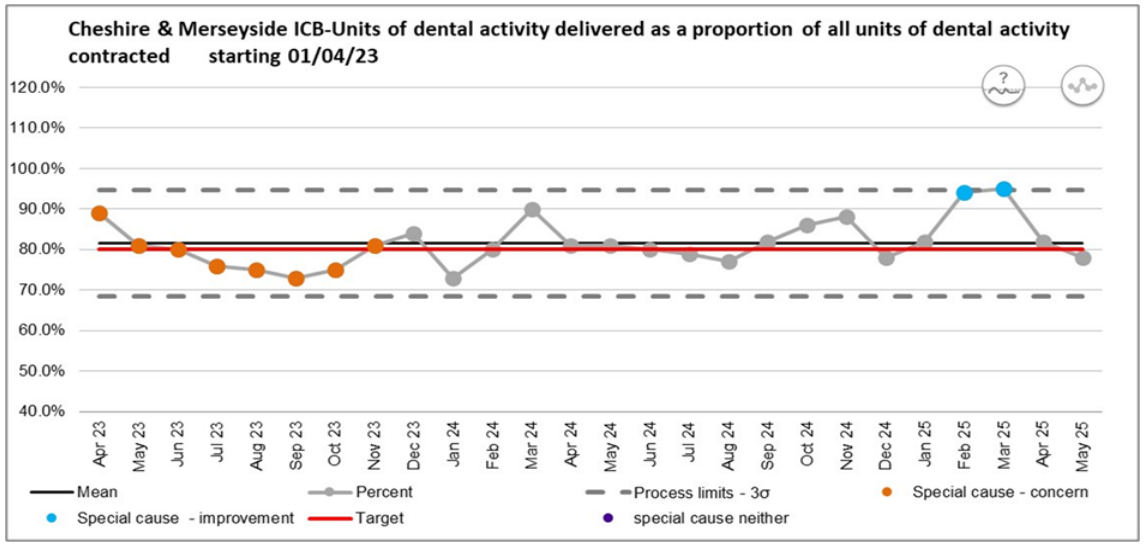
5. Exception Report – Primary Care

NHS Cheshire and Merseyside

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

Latest ICB Performance (May-25)	78.0%	National Ranking	34/42

ICB Trend (May-25)



Issue
- C&M does not currently meet the 100% target.

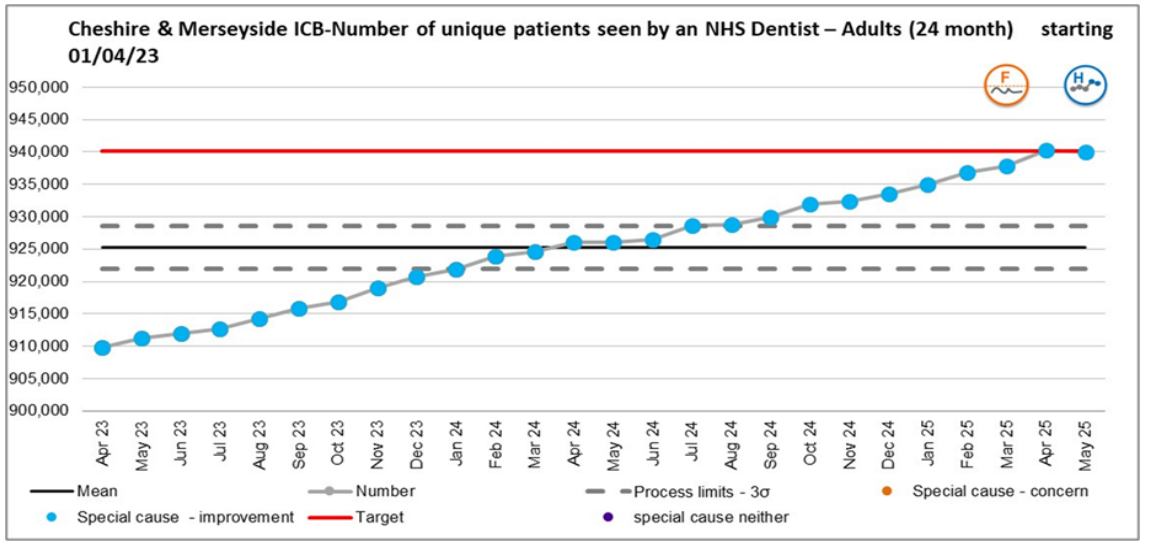
Action
- Local Dental Improvement Plan 25/26 implementation.
- Consideration to reallocation of UDA's where appropriate should there be any contract hand backs to maximise activity.
- Delivery of national urgent care programme and increased activity.

Delivery
- Fluctuations in delivery of target are expected throughout the year such is the nature of national contract. The position for May 2025 is similar when compared to 2024 and 2023.

Number of unique patients seen by an NHS Dentist – Adults

Latest ICB Performance (May-25)	939,940	National Ranking	n/a

ICB Trend (May-25)



Issue
- Performance has slightly decreased and C&M does not currently meet the target. However, the long-term trend has been for sustained improvement.

Action
- Continue to support network of providers to see new patients who require an NHS dentist delivering Pathway 1/2/3 in local dental plan 25/26.
- Working with providers to ensure accurate and timely submission of data to BSA.
- Evaluation of local proof of concept practice to inform commissioning.

Delivery
- Commissioners are using flexible commissioning arrangements to improve activity.

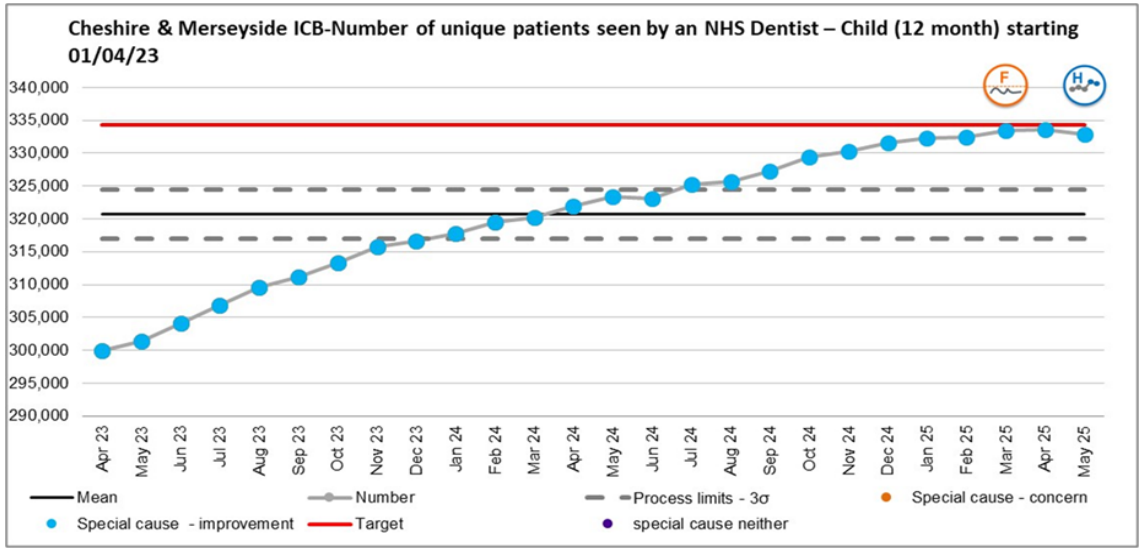
5. Exception Report – Primary Care

NHS Cheshire and Merseyside

Number of unique patients seen by an NHS Dentist – Children

Latest ICB Performance (May-25)	332,921	National Ranking	n/a

ICB Trend (May-25)



Issue
- Performance has slightly decreased and C&M does not currently meet the target. However, the long-term trend has been for sustained improvement.

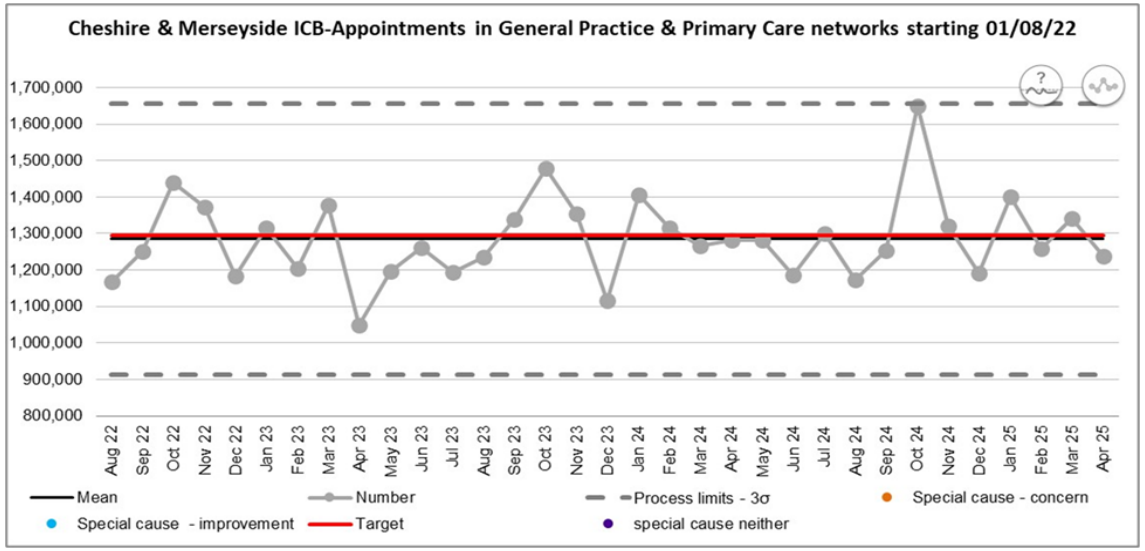
Action
- Continue to support network of providers to see new patients who require an NHS dentist delivering Pathway 1/2/3 in local dental plan for 25/26.
- Working with providers to ensure accurate and timely submission of data to BSA.
- Evaluation of local proof of concept practice to inform commissioning has commenced.

Delivery
- Commissioners are using flexible commissioning arrangements to improve activity.

Appointments in General Practice & Primary Care networks

Latest ICB Performance (Apr-25)	1,237,568	National Ranking	n/a

Place Breakdown (Apr-25) **NEW**



Issue
- Data continues to fluctuate around the target, but variation below is narrowing.

Action
- Implementation of June plan (submitted to NHS England 23/6) contains actions to reduce variation.
- Individual outlier actions to be put in place noting variation is around other data sets, not just number of appointments.

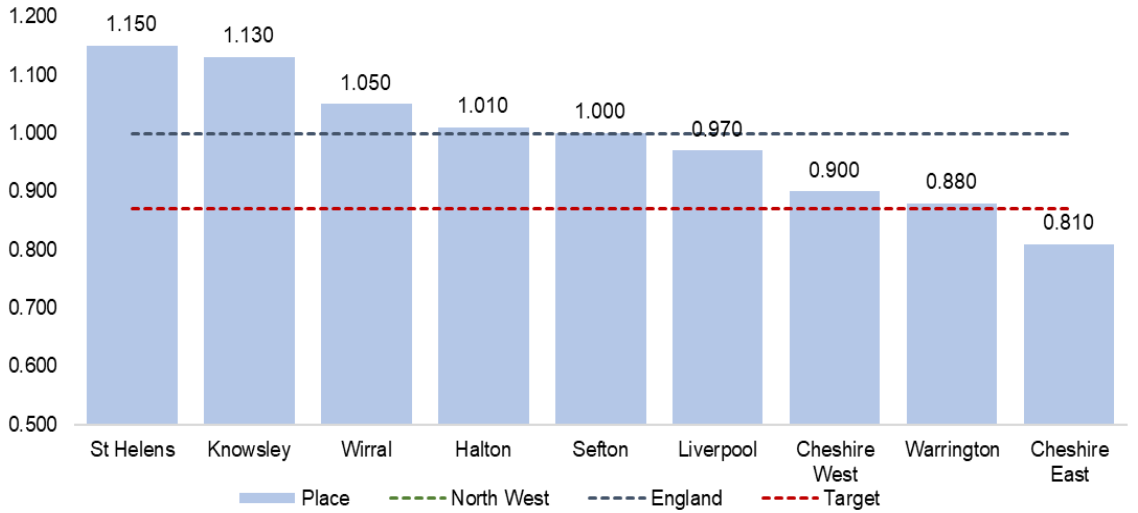
Delivery
- A more consistent approach to individual outliers is being adopted as part of primary care plans submitted to NHS England in June.

5. Exception Report – Primary Care

NHS Cheshire and Merseyside

Total volume of antibiotic prescribing in primary care

Latest ICB Performance (Mar-25)	0.97	National Ranking	n/a
ICB Trend (Mar-25)			Improved



Issue

- C&M does not currently meet the target set for the volume of prescribing of antibiotics.

Action

- All Places continue the cascade of education, public communication work, reviewing prescribing data and decisions in relation to antibiotic prescribing.
- Hydration pilot roll out continues across all places not involved in the pilot, via masterclasses focusing on key messages with care home staff.
- Central NHS C&M penicillin de-labelling inbox now live.
- Place AMR leads to submit quarterly update for placed based AMR activities to ensure appropriate oversight.

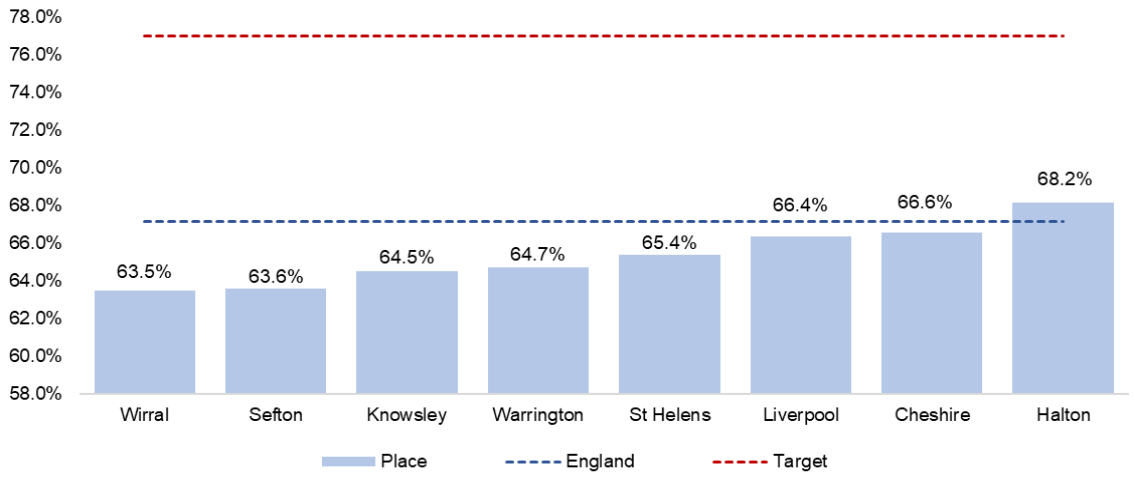
Delivery

- Analysis to continue with Q1 2025/26 data at Place and ICB level to inform areas to focus on at Place and C&M level.

5. Exception Report – Health Inequalities & Improvement

NHS Cheshire and Merseyside

% of patients (18+), with GP recorded hypertension, BP below appropriate treatment threshold			
Latest ICB Performance (Q3-24/25)	65.5%	National Ranking	29/42
Place Breakdown (Q3-24/25)			Deteriorated

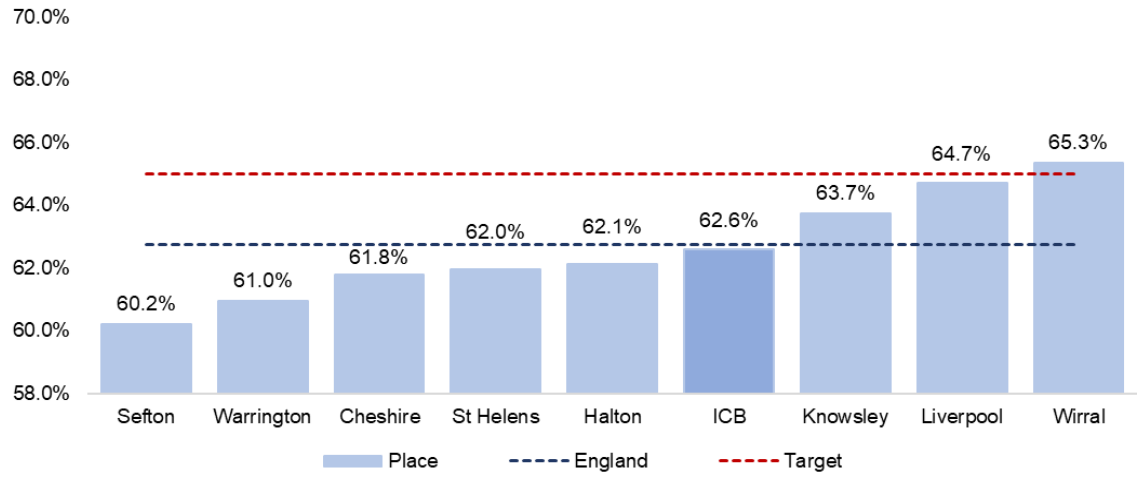


Issue
- Considerable variation in C&M, reductions in capacity & funding continue to affect performance; C&M does not currently meet the national target ambition.

Action
- The hypertension case finding in optometry pilot has received interest from practices in every Place and will go live in Q1 25/26.
- Cycle 1 of the CLEAR programme has begun. Work will start with the first 5 tranche of PCNs to adopt a new model of care around their chosen aspect of CVD prevention which may include hypertension.
- The Health Inequalities blood pressure optimisation project is underway, with 17 practices on boarded and completing work plans. Evaluation will be undertaken Q1 25/26.

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

% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with lipid lowering therapies			
Latest ICB Performance (Q3-24/25)	62.6%	National Ranking	19/42
Place Breakdown (Q3-24/25)			Improved



Issue
- Considerable variation in C&M, reductions in capacity & funding continue to affect performance; C&M does not currently meet the national target ambition.

Action
- A clinically led lipid management group has been established to ensure lipid management opportunities are being explored along the pathway.
- A mapping exercise is being explored to assess the current state of lipid services.
- Support for primary care to access the new offer for inclisiran prescribing and changes to QOF.
- Develop a suite of usable resources for primary care colleagues to support lipid management
- Cycle 1 of the CLEAR programme has begun. Work will start with the first 5 tranche of PCNs to adopt a new model of care around their chosen aspect of CVD prevention which may include lipid management.

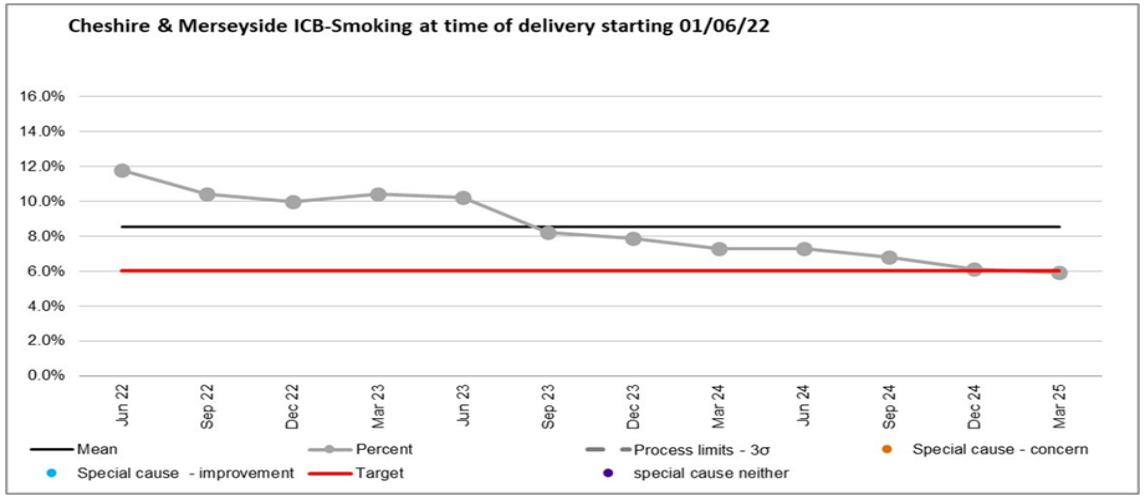
Delivery
- CVDP SRO, Programme lead and CVDP Board is the vehicle to coordinate C&M wide NHS activity alongside local Place CVD Prevention plans.
- The role of primary care in achieving this ambition is key.

5. Exception Report – Health Inequalities & Improvement

NHS Cheshire and Merseyside

Smoking at Time of Delivery

Latest ICB Performance (Q4-24/25)	5.9%	National Ranking	31/42
ICB Trend (Q4-24/25)			Improved



Issue

- Cheshire and Merseyside's (C&M) smoking at time of delivery (SATD) rates have continued to decline and have now fallen below the ICB target of 6%.

Action

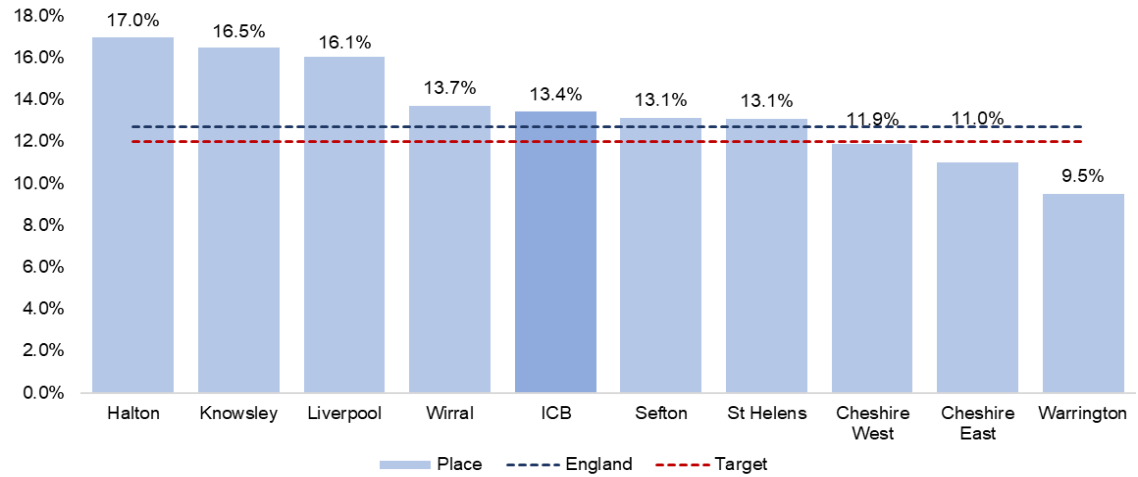
- Since the work on SATD commenced in Feb 2022 rates have more than halved due to the continued efforts of specialist staff working in maternity providers.
- In Partnership with the C&M Cancer Alliance the Smoking in Pregnancy project has been shortlisted for a HSJ Patient Safety Award.
- The achievements made in reducing smoking at time of delivery in C&M have been highlighted in a range of media articles which included a case study on a mum of four from St Helens who successfully quit smoking during her fourth pregnancy.

Delivery

- Currently SATD continues to improve each quarter with the ongoing ambition that C&M will continue to see a reduction in the number of women smoking at the time of delivery as we move into 2025/26.

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

Latest ICB Performance (Feb-25)	13.4%	National Ranking	n/a
Place Breakdown (Feb-25)			Improved



Issue

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

Action

- The public facing communication campaign "Smoking Ends Here" was launched on No Smoking Day (12 March 2025) in Liverpool and Chester with significant media coverage.
- The new website https://smokingendshere.com has been developed and launched, the website is a one stop shop for smokers from across Cheshire and Merseyside to find information on stopping smoking and details of their nearest stop smoking services.
- A workforce training and development review has been completed and a workforce training and development plan has been developed.

Delivery

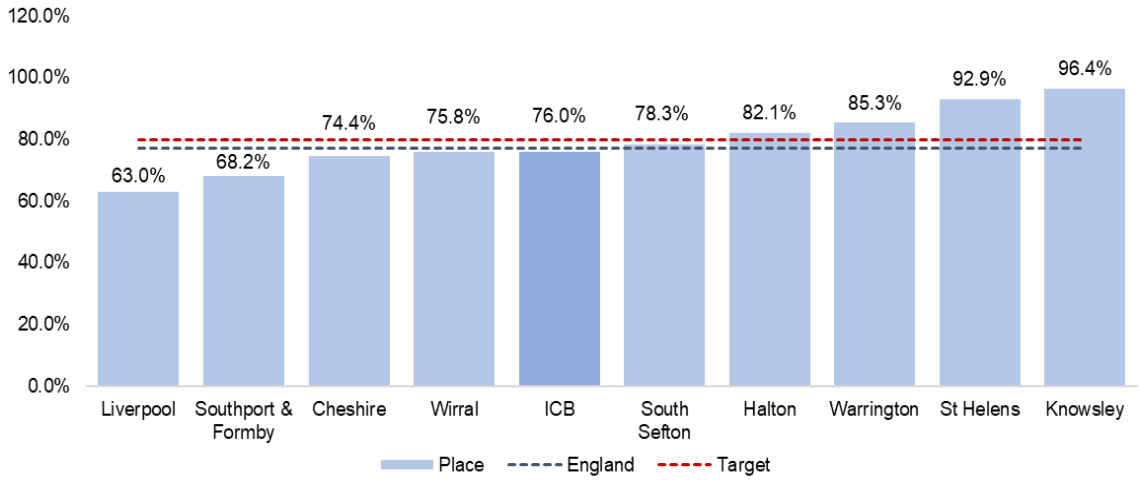
- Smoking prevalence continues to decline in C&M but requires a continued Whole System Approach to ensure progress is maintained.

5. Exception Report – Continuing Healthcare

NHS Cheshire and Merseyside

Standard Referrals completed within 28 days

Latest ICB Performance (Q4-24/25)	76.0%	National Ranking	27/42
Place Breakdown (Q4-24/25)			Improved



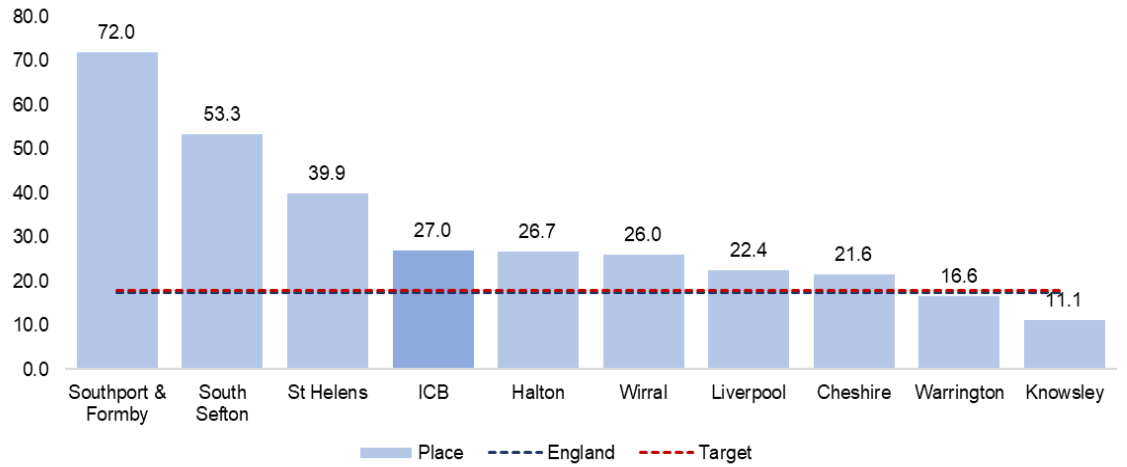
Issue
- Cheshire and Merseyside ICB is not currently meeting the NHS England KPI for Standard CHC referrals to be completed within 28 days. The target is 80%.

Action
- A review of AACC delivery across C&M has taken place to develop a single structure and improve consistency and capacity across the 9 sub-locations. This includes the in-housing of Liverpool and Sefton place-based teams, which are the main outliers for this metric.
- Additional scrutiny of the in-housed service has enabled allocated senior clinical resource to daily management of 28 day / long waits.

Delivery
- The ICB delivery was slightly below the quarterly trajectory agreed with NHS England in Q3. The projection was ≥75% to 77.9% although improvement was made and the delivery has improved further to 76% in Q4.

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

Latest ICB Performance (Q4-24/25)	27.04	National Ranking	38/42
Place Breakdown (Q4-24/25)			Improved



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

Action
- NHS C&M ICB are producing a suite of supportive policies and procedures to support teams in delivering consistent delivery and application of NHS CHC across the C&M system. Some are already operational and published whilst others are in various stages of ratification and development.
- The main impact upon this metric is with the place teams that are, or were, outsourced; in-housing will enable improved scrutiny over delivery.

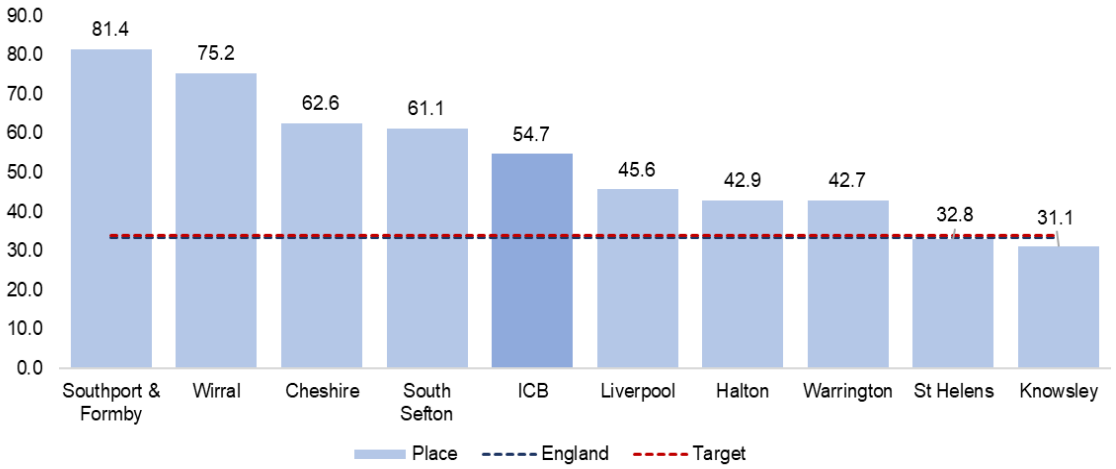
Delivery
- A focused piece of work in Liverpool and Sefton through outsourcing of Fast Track reviews as well as the implementation of the revised structure should ensure that only those individuals who are eligible for Fast Track are in receipt of the funding.

**snapshot at end of quarter*

5. Exception Report – Continuing Healthcare

Cheshire and Merseyside

Number eligible for standard CHC per 50,000 population *			
Latest ICB Performance (Q4-24/25)	54.67	National Ranking	39/42
Place Breakdown (Q4-24/25)			Deteriorated



Issue

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

Action

- The main outliers for this metric are Southport and Formby, Wirral, Cheshire and Sefton. Sefton, Southport and Formby are still fairly recently in-housed teams and some positive action has been seen within other metrics.

Delivery

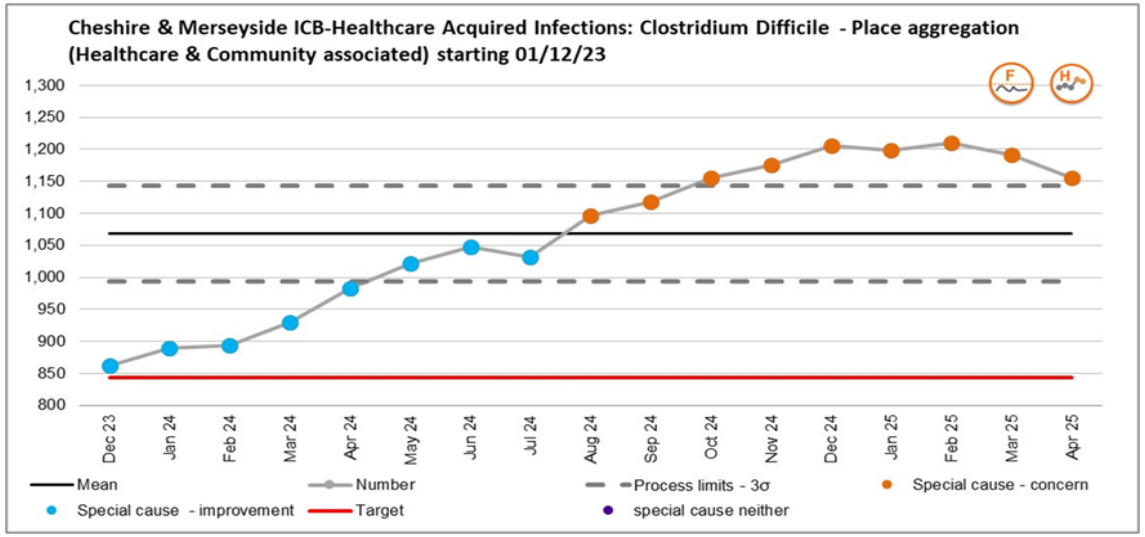
- Delivery is not expected to be improved significantly within this financial year but the Management of Change and consistent application of processes is intended to support a revised position over the financial year of 25/26. (Figures may also be impacted by demographics.)

**snapshot at end of quarter*

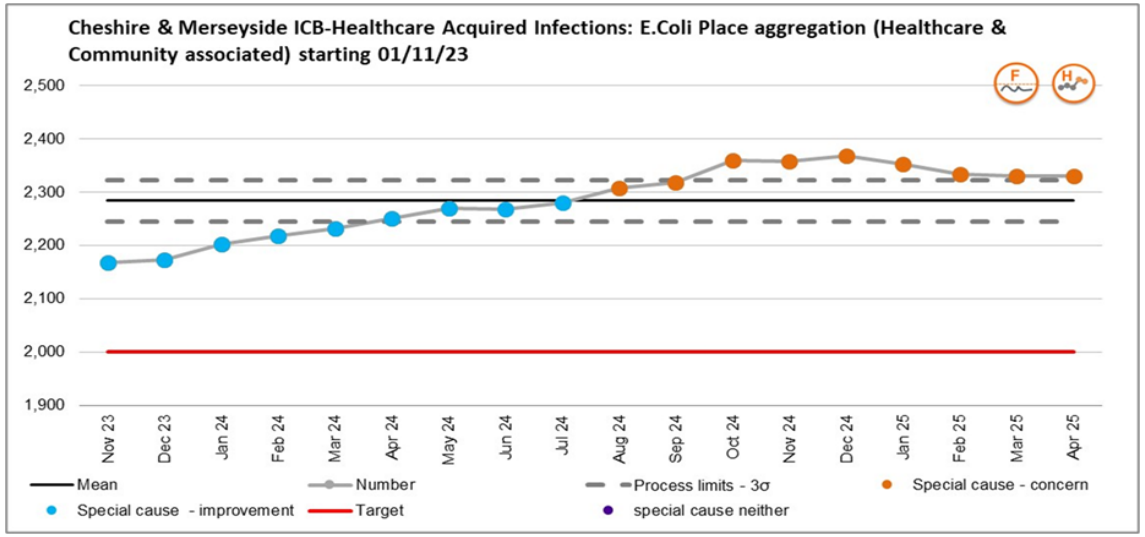
5. Exception Report – Quality

NHS Cheshire and Merseyside

HCAI: Clostridium Difficile - Place aggregation (Healthcare & Community associated)			
Latest ICB Performance (12 months to Apr-25)	1,155	National Ranking	n/a
ICB Trend (rolling 12 months to Apr-25)	Improved		



HCAI: E.Coli Place aggregation (Healthcare & Community associated)			
Latest ICB Performance (12 months to Apr-25)	2,330	National Ranking	n/a
ICB Trend (rolling 12 months to Apr-25)	No change		



Issue

- The C&M rate of CDI has continued to show a decline and is an early sign of progress with CDI Toolkit. Reductions were observed at COCH, ECT, MWL, MCHT, WHH and WUTH. Despite this both WUTH and COCH remain a high outlier on 12 months rolling data.
- The C&M rate of E. Coli has not changed this month following recent improvements. LUFT remain a high outlier in 12-month data and CCC have continued to report significant increase in cases and noted as a having the highest rate of E. coli per bed days across all hospitals in NW on a rolling 12-month period.

Action

- There has been a newly established HCAI Review Group to increase oversight with regards to HCAI rates and actions being taken to reduce. All providers with increased rates of HCAI are supported with regular discussions through the quality contract meetings to seek assurance and challenge progress.
- The development of a CDI improvement programme via CMAST has been implemented across all Trusts.
- Targeted review of GNBSI has taken place with LUFT and Mersey Care as local place IPC partners.
- Place-based teams are seeking to understand positive learning from providers with low outlier positions.

Delivery

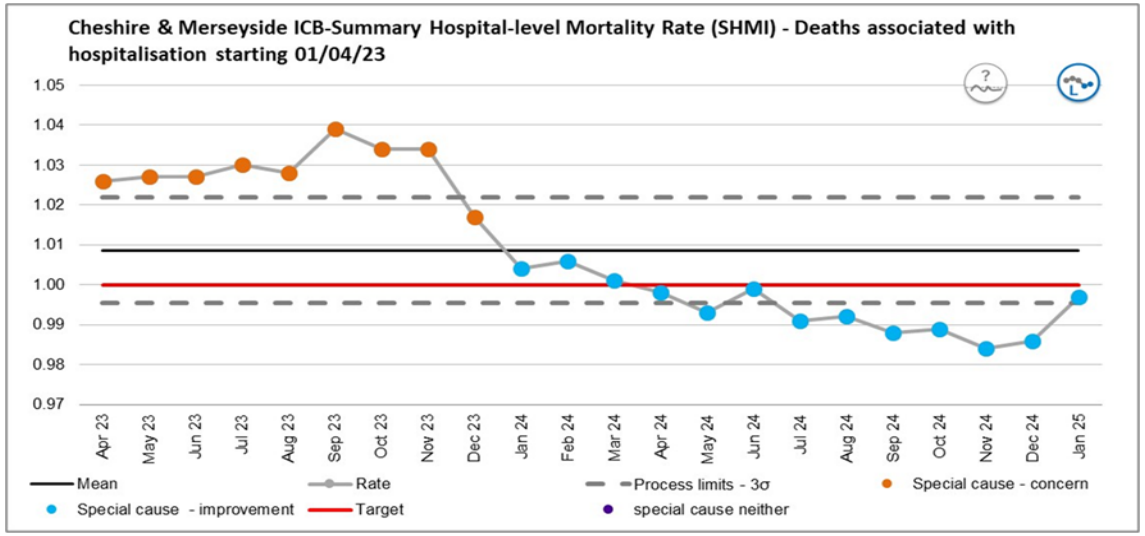
- The ICB tolerance for both CDI and E. Coli were breached in 2024/25, a further significant reduction will be required in 2025/26 to prevent tolerance breaches in year.

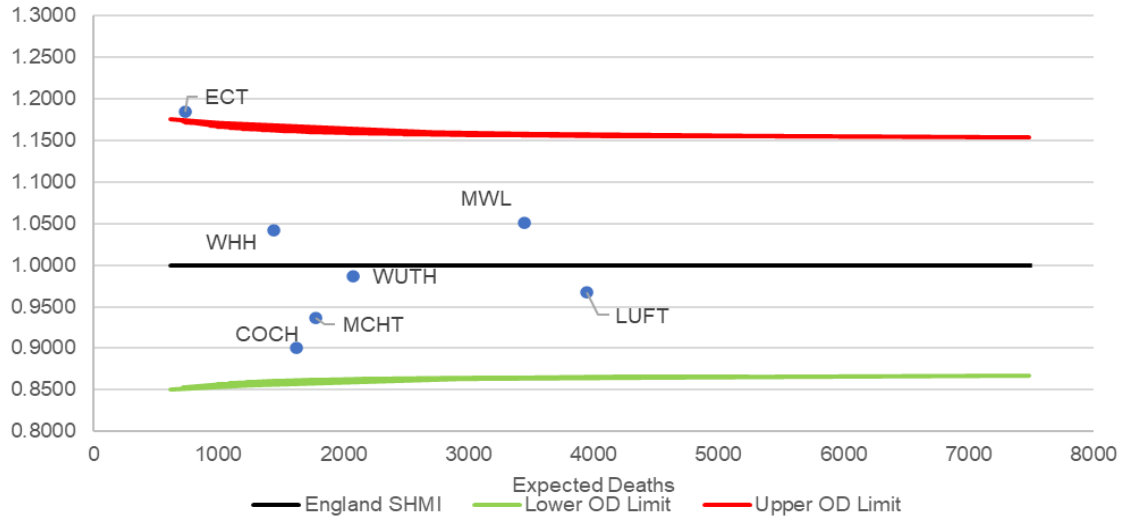
5. Exception Report – Quality

NHS Cheshire and Merseyside

Summary Hospital-level Mortality Indicator (SHMI)

Latest ICB Performance (Jan-25)	0.997	National Ranking	n/a
Provider Breakdown (Jan-25)*			Deteriorated





Issue
- C&M trusts are within expected tolerances except ECT, with a current value of 1.1842 against the upper control limit for ECT of 1.1723.

Action (ECT only)
- The trust has moved to quality improvement phase of quality governance/escalation.
- Scrutiny continues between the ICB and trust in board-to-board meetings and system oversight reviews ensuring the optimal support is in place to bring about best patient outcomes.
- Following the meeting of ICB and trust execs and board, further developed improvement plans and support have been agreed and a detailed timetable of support and assurance created.
- Early indication of improved rates of hospital acquired infection will not be reflected in SHMI, but monthly reporting scrutinised by trust and ICB Medical Directors.

Delivery
- SHMI has improved and is at the edge of the 95% confidence interval.
- The improvement culture in the trust is palpably improved and a Board to Board review in November has led to next steps including a review using HSMR+ that has demonstrated a significantly frail elderly population and clear improvement in mortality when measured using the HSMR+ methodology. HSMR+ remains inside the 95% confidence interval on funnel plot and oversight continues.

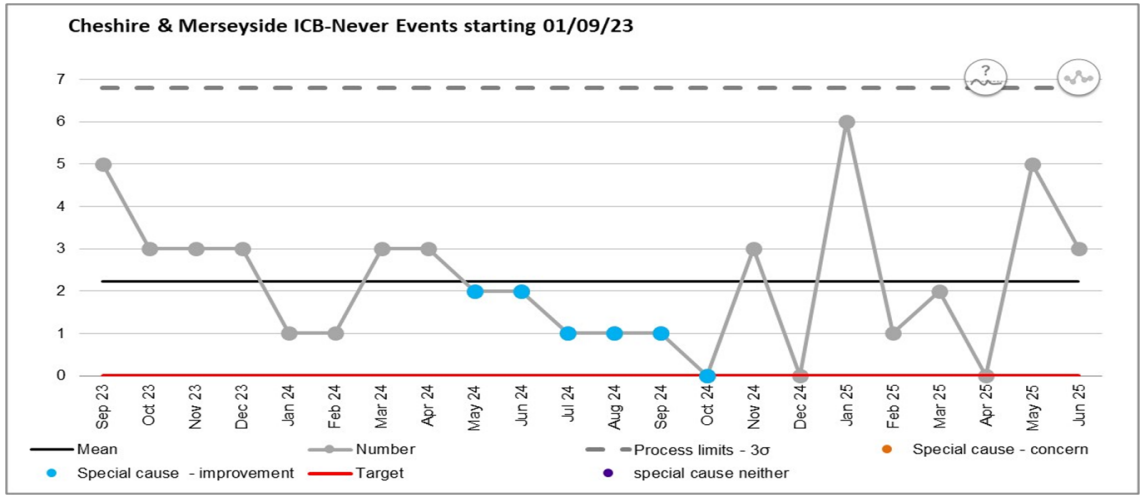
** OD, overdispersion, adds additional variance to the standard upper and lower control limits*

5. Exception Report – Quality

NHS Cheshire and Merseyside

Never Events

Latest ICB Performance (June-25)	3	National Ranking	39/42
Place Breakdown (June-25)			Improved



Issue

- A further spike in Never Events in May to 5 has seen the 12 month rolling position increase to 22 cases from 19 cases last month, however this remains lower than the rolling 12 month position at May 24 of 26 cases.
- The 5 cases in May related to two guide wire issues in COCH, a misplaced NG tube and a wrong site surgery at WUTH and wrong route medication at LUFT.

Action

- All cases are subject to ongoing investigation and 4 of the 5 cases will be discussed at the invasive procedures clinical network for sharing learning.
- The wrong route medication has been shared with the ICB medication leads for discussion with Medication Safety Officers.

Delivery

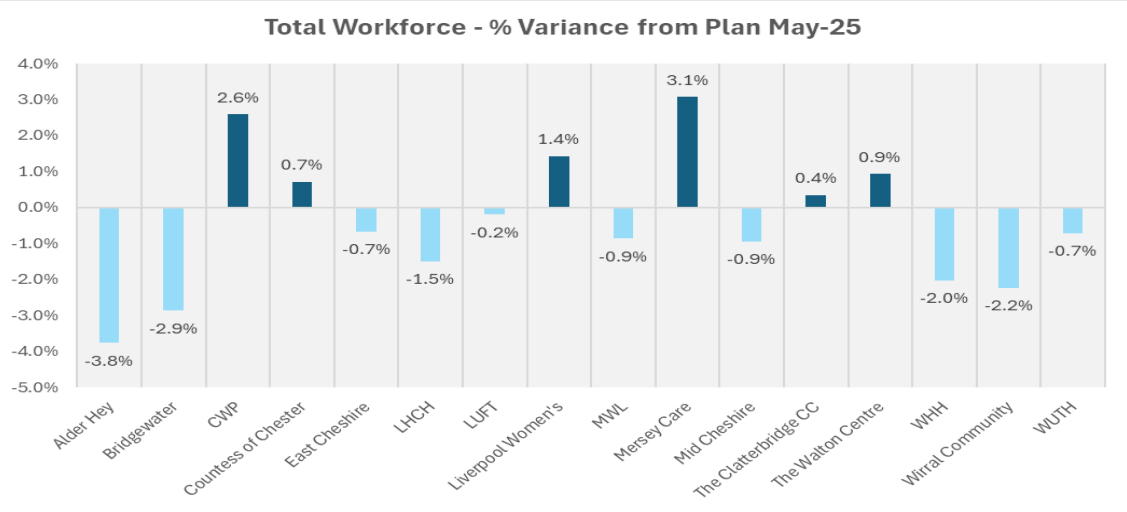
- The intention for a continued reduction in Never Events continues and whilst an increase in reporting month continues a long term reduction year on year.

5. Exception Report – HR/Workforce

Cheshire and Merseyside

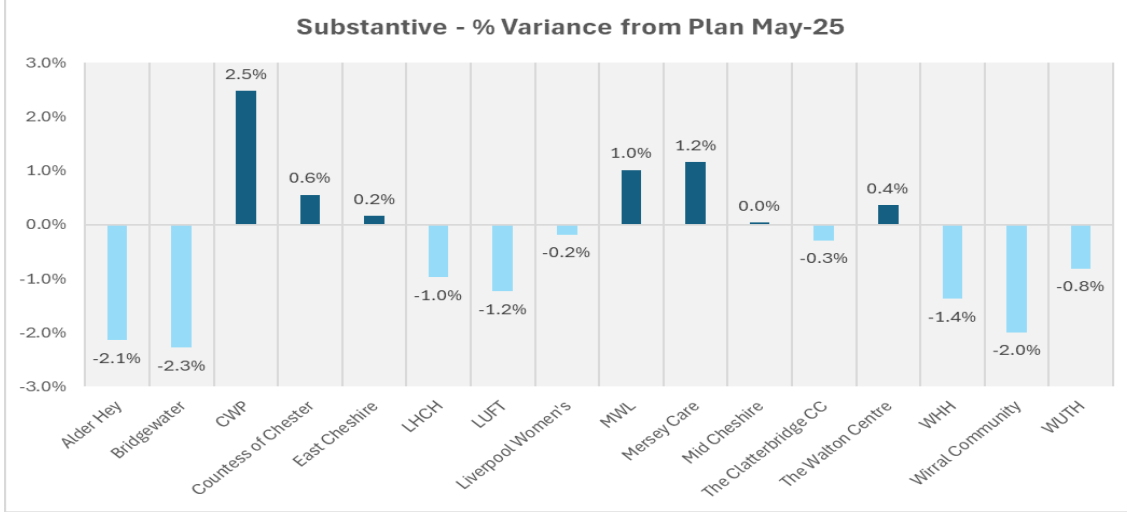
Total SiP (Substantive + Bank+ Agency) Variance from Plan % - via PFRs	
C&M ICB Performance (May-25)	**-0.1%**

Provider Breakdown (May-25)



Substantive Variance from Plan % - via PFRs	
C&M ICB Performance (May-25)	**-0.2%**

Provider Breakdown (May-25)



Issue

- In May-25, ten of the sixteen C&M Trusts reported their total workforce WTEs were below their planned figure as at M02, with a C&M variance from plan of -0.1% (-70.3 WTE). These variances are based on the new 2025/26 Workforce Operational Plan submissions with monthly forecasts for WTE for 25/26. Although overall WTE utilisation is lower than planned across C&M - a cross-check with finance / pay costs shows that the pay bill is above plan by £8.2m overall.
- Nine of sixteen C&M Trusts reported substantive staff in post numbers lower than that forecast in their operational workforce plans. The total system performance was a variance from plan of -0.2%. At a system level, substantive staff utilisation decreased by -51.8 WTE / -0.1% from the previous month.

Action

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

Delivery

- Workforce workstreams for Sustainable Nursing Workforce Changes & Medical Workforce Changes has been stood up in May 2025 – reporting into FCOG – Financial Control & Oversight Group.
- Proactive monitoring of workforce data & proposed actions now takes place with Trust Chief People Officer & workforce/resourcing teams.

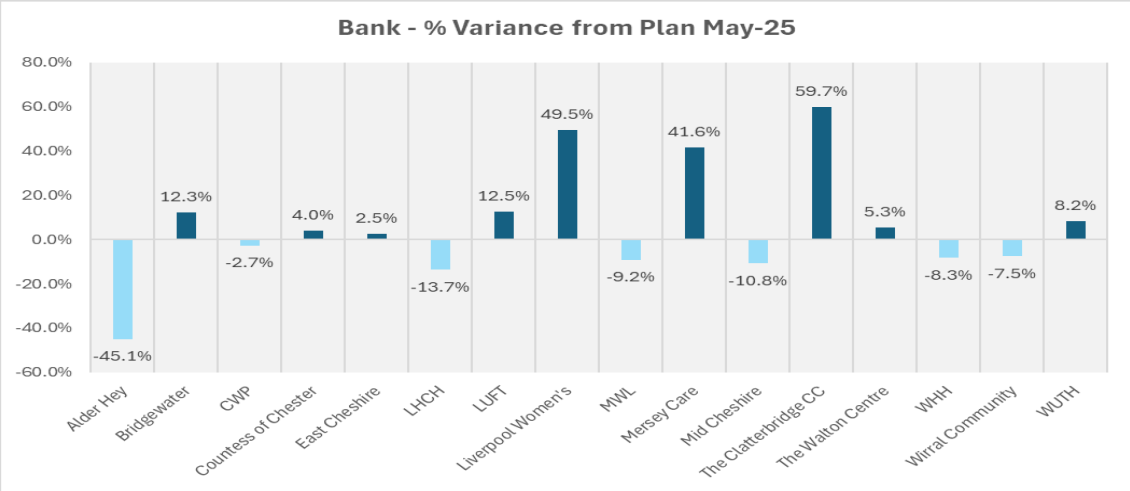
5. Exception Report – HR/Workforce

NHS Cheshire and Merseyside

Bank Variance from Plan % - via PFR

C&M ICB Performance (May-25)	6.1%

Provider Breakdown (May-25)



Issue

- Nine of sixteen C&M Trusts had Bank usage higher than that forecast in their operational workforce plans for the month of May-25. The total system performance was a variance from plan of +6.1% / 293.9 WTE.
- At a system level, the total bank usage decreased by -114.5 WTE / -2.2% from the previous month.

Action

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

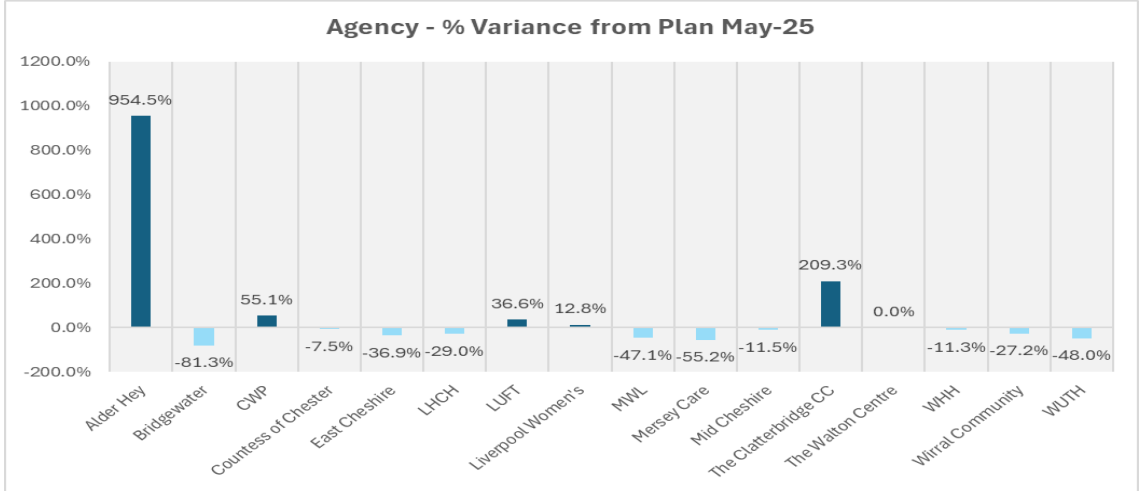
Delivery

- Proactive monitoring of workforce / pay cost data & proposed actions/controls for the coming quarter with Chief People Officers C&M Trust PDN Network focussed workstream.

Agency Variance from Plan % - via PFR

C&M ICB Performance (May-25)	-28.4%

Provider Breakdown (May-25)



Issue

- Ten of sixteen C&M Trusts had Agency usage lower than that forecast in their operational workforce plans for the month of March. The total system performance was a variance from plan of -28.4% / 247.4 WTE.
- At system level, Agency usage reduced by -20 WTE / -3.1% from the previous month.

Action

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

Delivery

- Proactive monitoring of workforce data & proposed actions/controls with Chief People Officers C&M Trust PDN Network focussed workstream
- Proactive communication to Chief People Officers, Workforce & Resourcing Teams about Off-Framework and Agency Spend data (by staff group) is shared monthly with additional input provided by NHSE North West.

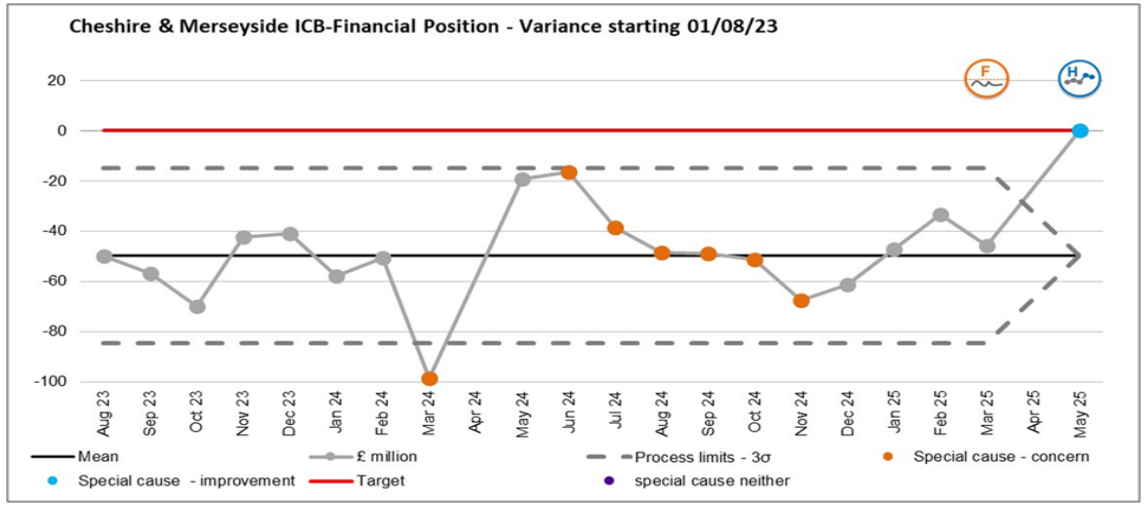
5. Exception Report – Finance

NHS Cheshire and Merseyside

Overall Financial position Variance (£m)

Latest ICB Performance (May-25)	+0.2	National Ranking	n/a

ICB Trend (May-25)



Issue

- System reported deficit of £67.1m against at year-to-date deficit plan of £67.3m as at M2 (ICB - £8.4m surplus, providers £75.5m deficit)
- This position is £0.2m more favourable than the year to date plan. The surplus is across providers with the ICB position being in-line with plan.
- ICB adverse variances at month 2 are Ophthalmology overperformance within independent sector providers, ADHD services, All age continuing care and slippage on efficiency savings.
- Provider key issues – shortfall on CIP delivery, pay expenditure in excess of YTD plan with bank expenditure currently above the NHSE bank ceiling and diminishing cash levels with four organisations expected to apply for external cash support.
- System received Q1 of the £178m deficit support funding in month 2 which has been distributed to providers .

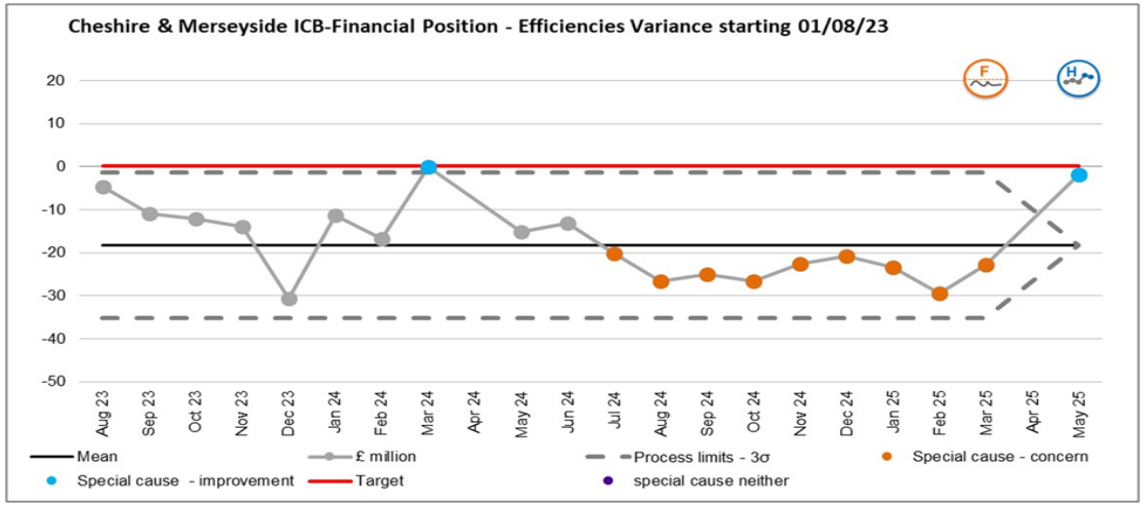
Action

- Key focus on management of YTD position and system run rate.

Efficiencies Variance (£m)

Latest ICB Performance (May-25)	-1.9	National Ranking	n/a

ICB Trend (May-25)



Issue

- System delivered £61m of efficiencies as at month 2 against a plan of £62.9m leading to a shortfall of £1.9m.
- Shortfall is £1.5m across providers and £0.4m for the ICB.
- Key areas of ICB efficiency slippage are within schemes to reduce the number of out of area MH placements and medicines prescribing savings.
- 80% of the system's efficiency plans are either fully developed or plans are in progress with 20% being sought as an opportunity or as yet unidentified.

Action

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

Delivery

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

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

Highlight report of the Chair of the Quality & Performance Committee

Agenda Item No: ICB/07/25/09

Committee Chair: Tony Foy, Non-Executive Member

Highlight report of the Chair of the Quality & Performance Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	12 June 2025

Key escalation and discussion points from the Committee meeting

Alert

Vaccination Programme

- Recent data indicates a significant decline in seasonal vaccination rates in the UK across all eligible cohorts, especially compared to pre-Pandemic levels. In order to improve uptake a system wide response is needed with the ICB as strategic commissioner and system convenor.
  Health Care Workers Whilst uptake in the ICB providers remains above regional and National levels at 39.7% all providers except Merseycare have seen a reduction. C&M has recently commissioned insight work with Health Care Workers to ascertain what shaped their decision about whether to accept the Covid-19 and/ or Flu vaccination in 24/ 25. Whilst a full report is due at the end of June 2025, initial findings highlight that there are some barriers that influence whether the vaccine is accepted, for example:
  - Lack of time/ convenience to get the vaccine
  - Post-Pandemic vaccine mistrust particularly re: Covid-19 vaccination
  - Low perceived personal risk
  - Vaccine fatigue

  There are also key enablers that support vaccination uptake, for example: Advance notice of on-site drop-in and mobile clinics; routine, integrated messaging with emphasis on choice

  Flu vaccine - although there had been an improvement overall in relation to flu vaccination uptake in Cheshire and Merseyside, there was a variation in terms of PCN performance, North Liverpool and South Sefton were currently the lowest performing. There had been a continued decline in the uptake for covid vaccinations in the last 3 years.

Quality

- Warrington and Halton Hospitals are undergoing a significant integration journey with Bridgewater Community Healthcare and a number of recent incidents have prompted the desktop review. The areas of emerging concern relate to surgical safety, maternity stability, management of sepsis, deteriorating patient and efficiency and outcomes from surgery. The review utilised intelligence held by Central Patient Safety, Place Quality and Safety and LMNS colleagues, alongside published data and board reporting. The Trust acknowledges much of the intelligence described within board reporting and indicates action being taken to address issues. The Trust has actions in place including; sepsis recognition and management, transformative work on urology/breast surgery/gynecology and

maternity diverts with LMNS support. A key recommendation seeks to improve visibility of the specific action and outcome at the Trust. The desktop review also identified some specific findings not visible within Trust board papers, and it is recommended that these findings are discussed with Trust representatives to seek their understanding and internal assurances that may not currently be visible to the ICB.

Advise

Safety (surgical)

- Warrington & Halton Trust requested a MIAA audit of Theatre which was prompted by five Never Events recorded during the 2023-2024 period, highlighting significant patient safety concerns and gaps in protocol adherence. The audit resulted in a Limited Assurance Opinion. A risk assessment identified low-to-moderate risks to patient safety with current controls. This indicated that the Steps to Safer Surgery were not fully embedded in theatre practice. The Trust has responded with an action plan comprising of 17 actions. Progress is being monitored internally via the Patient Safety Steering Group (PSSG) and a new theatre governance group. Initiatives include a digital audit dashboard, a national training video, and the development of a Surgical Safety Champion role.

Maternity update

- Improvement in induction of labour rates
- Reduction in IOL delays over 12 hours and 24 hours respectively
- eSITREP is now able to measure cancellations of planned caesarean sections. Overall, the numbers are very small and majority of providers are able to reschedule within 12 hours.
- An introductory site visit to East Cheshire Trust took place on 13th May 2025 led by the LMNS team with attendance from ICB Place, MNVP and the North West Regional Team. Immediate actions were agreed, including the provision of additional support to the Trust through the Joint Oversight and Support Framework.

Urgent and Emergency Care

- Although achieving the internal trajectory in April for 4 hour waits, C&M current performance is 5.3% below the national ambition of 78%, placing the ICB 27th out of 42 ICBs in England.
  15.9% of patients attending emergency departments (EDs) experienced delays exceeding 12 hours. This compares with the North West average of 13.2% and the national average of 9.7%. While some improvement has been noted over the past month, continued efforts are required to drive down patient delays and improve performance against the standard. 12 hour waits continue to be a challenge with ICB ranked 37/42 nationally with 15.9% and three Trusts (Countess of Chester, Wirral and Warrington and Halton) significantly above C&M and North West levels. Actions include expansion of Same Day Emergency Care across Cheshire and Wirral, advanced discharge and flow initiatives in COCH, MCHT, and ECT including early discharge projects.

Assure
Safety systems • The Patient Safety Report highlighted the progress with review and evaluation of the first 12 – 18 months of PSIRF within NHS Organisations, the roll out and implementation of LFPSE. Progress has been made against some other key elements of the NHS Patient Safety Strategy, with specific focus on the National Patient Safety Syllabus. The Learning from Patient Safety Events system continues to be adopted with support provided to General Medical Practice before plans to support wider Primary Care and Social Care adoption. The system is presenting a significant (high volume) source of intelligence around patient safety but requires further support nationally to allow efficient analysis. **Healthcare Associated Infections** • The C&M context is similar to the national picture (reducing total antibiotic prescribing but increasing rates of broad-spectrum antibiotics) , however with significant variation between providers. With strong antimicrobial stewardship increases in broad spectrum antibiotics have not returned to 2019 proportions locally as reported nationally. The local rate of change between the years of 2020/21 and 2023/24 has varied significantly between providers with the greatest increase in rates at 165% and greatest reduction of 72%. 9/12 organisations have seen an increasing rate and 5 of these are above the 33% national position. Two organisations have seen a reducing rate and one static. The ICB had already commenced focused work with several providers with significant rates of infection and planned work with providers with emerging concerns due to recent increasing rates. The areas of increased investigation and focus recommended within the national report have all been included within the work of CMAST provider collaborative in development of the C&M CDI tool kit. This is currently being adopted by NHS providers in order to address current CDI rates.

Committee risk management

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

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
P4 major quality failures	1. Warrington and Halton Hospitals quality review. 2. HCAI rates and system actions

Board Assurance Framework Risks	
P1 Health Inequalities	Vaccination Programme – clinical staff uptake and Place variation

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Urgent and Emergency Care	Review of key measures – capacity and improvements challenged Trusts
Maternity	Review of performance standards – exception reporting.

Appendices

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

Highlight report of the Chair of the ICB Audit Committee

Agenda Item No: ICB/07/25/10

Committee Chair: Tony Foy, Non-Executive Member

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Audit Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	10 June 2025

Key escalation and discussion points from the Committee meeting

Alert

The Audit Committee at its 10 June 2025 meeting:

- received a report on the Cyber Assessment Framework (CAF) aligned Data Security and Protection Toolkit (DSPT) which focused on the ICB's progress toward meeting new national cyber security requirements. The report outlined that the DSPT audit took place on 13 May 2025, with a first draft expected mid-June, and that evidence was being uploaded ahead of the final submission deadline of 30 June 2025. While most assertions were supported, a few required additional IT evidence from service providers. NHS England had indicated that most ICBs would not meet around eight outcomes in the first year of CAF alignment, and any gaps would be addressed through an Improvement Plan submitted alongside the DSPT. The update also noted that the ICB's training rollout targeted staff handling patient data, and five minor data incidents occurred in Q4, none reportable to the ICO. The ICB was actively collecting evidence from providers and IT suppliers to meet CAF requirements, with an internal audit scheduled to ensure readiness. Following consideration of the report, the Committee **APPROVED** the recommendation to submit the ICB's 2024/25 DSPT audit to NHS England and noted progress toward compliance with CAF-aligned standards

- received the final draft versions of the ICBs Annual Report and Accounts 2024-25 for final review and comment prior to consideration by the ICB Board at its June 2025 meeting. Following the receipt and review of the External Auditors Findings Report and Head of Internal Audit opinion, and further discussion about changes to the report since the Committee last reviewed, the Committee **ENDORSED** the final draft version and **SUPPORTED** the recommendation that the Committee Chair would recommend the Annual Reports approval by the ICB Board.

- reviewed the Committee Risk Register Report which outlined the current high-rated risks under its remit. The report identified four active risks rated as high and recommended the closure of one risk - **G10** - relating to the re-procurement of information governance services, which is now considered stable. The Committee discussed the report and **APPROVED** the closure of risk G10.

Advise

The Audit Committee at its 10 June 2025 meeting:

- received a summary update regarding the waivers raised during the period 01 March 2025 and 31 May 2025 in relation to compliance with the ICB's Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation. It was highlighted that 20 waivers totalling c22.8m had been approved during this period. The Committee noted the report.

- received an update paper providing details on the robustness of cyber security arrangements across the Cheshire and Merseyside system and progress in delivering the Cyber Security Strategy. The Committee heard that despite limited progress in 2024/25 due to national funding withdrawal, there had been a number of key developments include the formal approval of the Digital Incident Management Plan by the Local Health Resilience Partnership (LHRP) and the establishment of a new Cyber Management Group to oversee risk reporting and governance. A Cyber Vulnerability Management Plan is underway, addressing system-wide risk registers, best practice standards, supplier management, and incident response readiness. The strategy aligns with national objectives such as "Defend as One" and supports ICB strategic goals including quality, integration, and leadership. The Committee noted the report.

- received the quarter 4 ICB Freedom of Information (FOI) report. The report outlined that the ICB received 135 FOI requests and responded to 141 during the quarter, achieving a 93% compliance rate in responding within the statutory 20 working days. There were 9 breaches of the statutory deadline, all due to delays in receiving information from internal departments (notably Clinical, Digital, Contracts, Estates, Finance, and CHC Services). On 5 occasions, initial responses were incomplete due to delayed internal inputs; full responses were later issued. For the full year 2024/25, the ICB received 537 FOI requests, slightly down from 542 in 2023/24. The Committee noted the report.

- received the quarter 4 ICB Subject Access Request (SAR) report. The report outlined that 18 SARS were received during this quarter and highlighted that while nearly half of the SARs were completed on time, a significant portion remained either open or breached. The breaches were primarily due to delays in receiving necessary information or clarification from applicants. The Committee discussed the breaches and plans for addressing. The Committee noted the report.

- received a report that provided an overview of the operation and performance of the ICBs risk management processes, as outlined within the Risk management Framework, up until quarter four of 2024/25 year. The report confirmed that critical and extreme risks are being escalated appropriately to the Corporate Risk Register (CRR), and high risks are being escalated to committee risk registers in most cases. Quarterly risk reports are being submitted to ICB committees and the Board, as required by the Risk Management Framework. It also outlined that there is strong compliance with the risk management process, with follow-up actions being taken where needed. The Committee discussed and noted the report.

- received a quarter 4 update report that outlined the current status of the ICBs Conflicts of Interest (COI) Management Framework and Declarations of Interest (DOI) compliance. The report reinforced the importance of effective DOI handling to ensure NHS decisions are transparent, fair, and legally sound. The report provided up to date information on the compliance of ICB staff in declaring any interests on the ICBs Civica Declare system (72%) as well as undertaking their COI training (78%) as well as details of declarations received and submitted during the quarter. The Committee noted the report.

- received the Head of Internal Audits Opinion 2024-25 which provides a comprehensive assessment of the ICBs governance, risk management, and internal control systems, and which highlighted that the ICB received an overall opinion rating of Substantial Assurance, indicating a good system of internal control that is generally applied consistently. The report outlined that no critical risks were identified; only one high-risk recommendation was raised, and that this opinion supported the ICB's Annual Governance Statement and reflected positively on its internal control environment. The Committee noted the report
- received the Internal Audit Plan progress report which provided Committee with an update on audit activity from April to May 2025 and outlined key developments for Audit Committee attention. the report highlighted that no critical or high-risk recommendations were overdue at the time of reporting. It highlighted that the one finalised review on Mandatory Training received a rating of Substantial Assurance, whereas of the reviews in progress that the Fit & Proper Person draft report was providing a Moderate Assurance and Risk Management Core Controls draft report a Substantial Assurance. The Committee noted the report.

- the committee received for noting the internal Audit Charter and the Global internal audit Standards briefing.

- received an Internal Audit Follow-Up Summary report which provided an update on the implementation status of audit recommendations from previous reviews. The report highlighted that a total of 26 recommendations were raised during 2024/25 with 1 high-risk, 11 medium-risk and 14 low-risk. No critical or high-risk recommendations were overdue at the time of reporting. The report highlighted that the ICB was demonstrating good progress in implementing actions, with follow-up reviews confirming that many recommendations had been addressed. The follow-up process is part of the 2025/26 Internal Audit Plan and will continue to monitor outstanding actions. The Committee noted the report.

- received the ICBs 2024-25 Counter fraud Annual Report which provided Committee members with a comprehensive overview of the ICBs anti-fraud activities, investigations, and compliance with national standards. The report highlighted that it aligns with the Government Functional Standard 013 for Counter Fraud, with the ICB achieving a 'green' rating across all 12 components. It also highlighted to members that. 42 fraud referrals were received in 2024/25, with 7 escalated to formal investigations, and that common fraud types included overlapping employment, mandate fraud, and prescription misuse. The report confirmed that the ICBs Anti-Fraud Plan was approved and delivered in line with national requirements, the ICB's fraud risk assessment was reviewed and updated and that no procurement or policy breaches were identified during proactive exercises. The Committee noted the report

- received the Anti-Fraud Progress Report for the ICB which outlined anti-fraud activities and outcomes from 01 April to 03 June 2025. Key areas highlighted included the approval of the 2025/26 Anti-Fraud Work Plan, submission of the annual Counter Fraud Functional Standard Return (CFFSR) to the NHS Counter Fraud Authority, achieving a 'green' rating across all 12 components, an update on the establishment from 01 April 2025 of a new dedicated investigations team, and current ICB compliance around fraud training (88.66% against a target of 95%.

The report outlined to Committee members that all key performance indicators were met, including timely case assessments and follow-up on recommendations. The Committee noted the report.

- received the MIAA Fraud Referrals Analysis Report (2021/22–2023/24) which provided a high-level overview of nearly 600 fraud referrals received across MIAA's 34 client organisations over the three-year period. The report highlighted that most referrals originated from acute NHS trusts, reflecting their size, complexity, and exposure. A significant number came from HR teams and the NHS Counter Fraud Authority's national reporting line. The most common referral type was NHS staff fraud—particularly working while sick—mirroring national trends. Other types included procurement fraud, patient prescription misuse, and external attempts to defraud the NHS. The report highlighted the importance of proportionate anti-fraud measures, especially in larger organisations, and the need for early detection and awareness.

- received the External Auditors' Annual Report for 2024/25 for the ICB which provided a comprehensive assessment of the ICB's financial statements and value for money (VfM) arrangements. The report outlined to Committee that an unqualified audit opinion was issued; no unlawful expenditure or statutory breaches were identified and that the financial statements were prepared to a good standard and supported by appropriate working papers. The Committee noted the report.

- received the 2024/25 External Auditors Audit Findings reports which provided a detailed assessment of the ICB's financial statements, internal controls, and value for money (VfM) arrangements. This report outlined that an unqualified audit opinion was issued, the financial statements gave a true and fair view and comply with all relevant standards and legislation. No material misstatements were identified, and several disclosure amendments were made, including corrections to financial instruments, joint operations, and remuneration disclosures. The report further outlined that no significant weaknesses were found in internal controls and that the only significant audit risk identified was management override of controls, where testing found no issues, but some control process improvements were recommended. No significant weaknesses were identified in VfM arrangements, governance arrangements were found to be sound, no issues were identified in relation to fraud, laws and regulations, or related party disclosures, and that the Annual Governance Statement and Remuneration Report were deemed compliant after minor amendments. The Committee noted the report.

Assure

n/a

The next meeting of the Committee is scheduled for **02 September 2025.**

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

Highlight report of the Chair of the System Primary Care Committee

Agenda Item No: ICB/07/25/11

Committee Chair: Erica Morriss, ICB Non-Executive Member

Highlight report 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	19 June 2025

Key escalation and discussion points from the Committee meeting

Alert

At its meeting in June 2025 the Committee considered:

- **M2 Finance Update** – Finance report did not include Medicine Management actuals to budget, we are verbally advised that pressure is already showing on this budget area as figures are collected across Primary Care. M3 will be actuals and potential mitigations and plans will be discussed at August SPCC.

Advise

At its meeting in June 2025 the Committee considered:

- **Strategy – Access Improvement** - The Committee approved the 'June Plan' submission, in line with the Operational Planning Guidance ask – this plan sets out how ICBs will address variation in access to primary medical services, through robust and consistent contract oversight and effective commissioning. The overall outcome expected is to support improved access to services and patient experience. Once this has been through national oversight the final version will return to the Committee. Steps already in place to support delivery were noted, including consistent use of data / indicators and internal oversight and governance. The board will be receiving a further update on this - and patient experience / feedback from colleagues at Healthwatch, at the meeting.

- **Estates** - Following Strategic Estates Board scrutiny and oversight, the Committee approved Premises Improvement Grants under the national Utilisation and Modernisation Fund 25/26 of £5,027,000, in line with the national Guidance. The Committee also endorsed the prioritisation methodology and change control process for the fund. In addition a presentation on the ICB Primary Care Estates programme was included -discussion flagged the importance of engaging with partners and investment in wider neighbourhood health as part of a strategic estates strategy.

- **Digital** - The Committee received an update in relation to digital transformation elements of primary care – including an update on the Blinx PACO pilot including feedback received and plans to continue the rollout to practices / PCNs who are

requesting to use the system. The outcomes of the pilot will be presented at the next Committee meeting.

- **System Issues -**The Committee received a general verbal update covering all four contractor groups on particular system issues and pressure points including ;
  - Primary Care implications in relation to the new weight management medication 'Tirzepatide' (brand name Mounjaro) being made available to NHS patient to support weight loss
  - Advised that Healthwatch Warrington had produced a report in relation to dental provision, which highlighted a number of issues that have been seen elsewhere, in particular a focus on the 0-5 year olds. Discussion to make sure the commitment in this area continues within urgent care work.
  - Noting all four contractor groups continued willingness to be involved in neighbourhood health plans and opportunities around this.

- **Contracting, Commissioning and Policy Update –** It was noted that the dental urgent care plan went live in April and performance is 18% off trajectory which is being monitored.The Delegation agreement for 24/25 was returned to NHS England as 'green' with no areas of concern raised in our response.

- **Prevention –** An update on the All Together Smiling (ATS) programme, – Cheshire & Merseyside's (C&M) supervised toothbrushing programme (STP) hosted by Beyond, Cheshire and Merseyside's Children's Transformation Programme on behalf of NHS Cheshire and Merseyside. The paper outlined work undertaken to address dental decay in children, with a focus on areas of highest deprivation. The committee requested information at a future meeting on the evidenced based commitment and the impact on funding going forwards. It was noted that there may be an initial increase in terms of finding dental decay because of this targeted work and impact would be felt over the longer term.

- **Commissioning - Advice and Guidance**. A paper to update the committee on advice and guidance, particularly in relation to the primary medical Enhanced Service was presented. The outputs of the ICB regional assurance/stocktake was noted and the volume of work and related governance was recognised. In relation to the Enhanced Service, in line with permissions with the specification and available budget, a cap was agreed for individual practices with a request for regular monitoring and a budget position returning to the committee before month 8.

Assure

At its meeting in June 2025 the Committee considered:

- **Finance -** the month 2 position was presented, and clarity was provided on an overspend position in the Delegated budget which was in relation to a particular place budget area being adjusted – a further overview on this will be given at the next meeting. Pressures on the QOF budget (Quality and Performance Framework) were noted and assurance was sought that available Capital budgets would all be spent/committed.

- **Primary Care Quality –** The Committee received an update on quality assurance in relation to the four contractor groups via the Primary Care Quality group - noting primary medical issues are managed within each place and then advised accordingly. Areas to alert, advise and assure were given and information regarding complaints was discussed. It was flagged that it is important to ensure positive feedback in relation to services is recognised and built on. It was noted that this report gave assurance to the committee, in the format presented, that there were robust processes in place and included the performance measurements used for all four contractor groups, noting for some contractors this was a nationally set framework/approach. For primary medical quality, the impact of the national GP dashboard work was also highlighted.

Committee risk management

Risks are returning to the Committee at the next meeting.

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

Focus Area	Key actions/discussion undertaken
Estate and Digital Capital 25/26	Agreed where indicated
Access	Agreement of the June plan submission which supports improved access to primary medical services

Date of Next Meeting: 14 August 2025

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

Highlight report of the Chair of the ICB Remuneration Committee

Agenda Item No: ICB/07/25/12

Committee Chair: Tony Foy, Non-Executive Member

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Remuneration Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	11 July 2025

Key escalation and discussion points from the Committee meeting

Alert

The Remuneration Committee at its 11 July 2025 meeting:

- received a report providing an update on the publication of the new national Very Senior Manager (VSM) framework which outlined the new pay ranges for key VSM roles within ICBs and NHS Trusts and which included details on performance and pay awards. The Committee reviewed the paper and approved the use of the Framework and its ranges for use in all future new VSM appointments

- received within the same report an outline of the recent national annual pay award for VSMs of 3.25% for 2025-26 and consideration for the Committee regarding applying the pay award. The committee decided not to apply the 3.25% VSM pay uplift for 2025/26 at this time for the ICBs VSMs, due to the ICB's significant financial challenges, likely redundancies, and the need to demonstrate financial leadership and control. It was agreed that this was a deferral for this year only, not a permanent rejection of applying the award

- received within the same report details with regards the ICB progressing the appointment of an interim Director of Finance appointment and approved the recommendation for the Chief Executive to be able to offer a salary that was within the range for Director of Finance roles as outlined within the new VSM Pay Framework

- received a report on and approved the proposed structure of the new Executive Team for the ICB with their associated Directorate structures. The Committee noted that there was further work to be completed with regards to the roles and benchmarking with other NHS organisations so as to help support the decision regarding salary ranges, in line with the principles outlined within the VSM Framework and existing ranges within the ICB.

Advise

The Remuneration Committee at its 11 July 2025 meeting:

- received an update report on the work underway regionally and nationally regarding the development of and approval of an ICB Voluntary Redundancy and Compulsory Redundancy schemes that are needed as a result of the running cost reduction challenge for ICBs that the Model ICB blueprint requires. The Committee was informed of the work required to be undertaken still by NHS England at both national and regional levels to enable approval of the schemes and the resulting delay to the initiation of the ICB staff consultation that has resulted. The Committee agreed that the ICB would need to formalise the financial risk to the ICB of the

costs of the ICB having to fund the redundancy schemes and where savings will be needed to be made.

- received a report providing an update on the recent Penny Dash letter regarding Chief executive and Chair job descriptions. The report outlined the national expectations for leadership and governance during the transition to the Model ICB structure. It provided revised draft role descriptors for ICB Chairs and Chief Executives which have stronger alignment with the Model ICB Blueprint and NHS 10 Year Plan, a comparison between the existing Chief Executive Job description and the draft new one and set out next steps for engagement and implementation. The paper highlighted to Committee members that the regional NHS England Director will look to have one-ones with Chairs and the ICB Chair to have a one-to-one with their Chief Executives to review the revised Job Descriptions and discuss personal impacts. Feedback was also to be provided to NHS England to support the finalisation of the job descriptions. The Committee discussed and noted the report.

Assure

n/a

The next meeting of the Committee is scheduled for **25 July 2025.**

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

Highlight report of the Chair of the ICB Children and Young Peoples Committee

Agenda Item No: ICB/07/25/13

Committee Chair: Raj Jain, ICB Chair

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Children and Young Peoples Committee

Committee Chair	Raj Jain
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	11 June 2025

Key escalation and discussion points from the Committee meeting

Alert

The Children and Young Peoples Committee at its 11 June 2025 meeting:

- considered a proposal to co-fund a dedicated Engagement Worker to strengthen young people's voice and participation across Cheshire and Merseyside. The role would be hosted by Youth Focus North West, with match funding of £20,000 from the VCFSE sector, and would look to identify and consult existing youth representation groups and experts by experience, facilitate young people's attendance and input into CYP Committee meetings, support planning of a youth-led conference/takeover day within 12 months and promote the Lundy Model of Participation and embed co-production across the system. The Committee endorsed the proposal with a commitment for ICB colleagues to investigate further where funding could be identified from within the ICB

Advise

The Children and Young Peoples Committee at its 11 June 2025 meeting:

- received an update report on progress around the Cheshire and Merseyside Neurodevelopment Pathway and which outlined a significant transformation in how neurodiverse children and young people will be supported across the region. Launched at the Committee meeting, members heard how the Pathway was developed collaboratively across all nine Places, with input from clinicians, professionals, families, and over 400 children and young people, the pathway marks a strategic shift from a diagnosis-led to a needs-led model, aiming to identify and support neurodiverse children earlier—ideally during primary school. Key features include:
  - the introduction of the "This is Me" profiling tool to support early identification and intervention,
  - establishment of Place-based neurodevelopment teams to provide a single point of access for families and schools.
  - a new standardised prioritisation tool to ensure timely access to assessment, with a target of no child waiting more than 52 weeks by March 2026.
  - a streamlined, multidisciplinary diagnostic process and shared care arrangements for ADHD medication.
  - ongoing support aligned to nine neurodevelopmental dimensions, with integration into education and mental health services.

  Committee members heard that implementation will be phased over 18 months, with oversight by the Neurodevelopment Pathway Oversight Group and progress tracked via a new ICB dashboard. The Committee noted the report, and the excellent progress made in Cheshire and Merseyside.

- received a Quarter 4 update on the NHS Cheshire and Merseyside Children and Young People's Mental Health Plan (2024–2026). The Q4 update highlighted steady progress across the eight priority areas of the CYP Mental Health Plan, despite significant financial pressures. Key developments included:
  - Access and Activity: Approximately 34,500 children and young people accessed NHS-funded mental health support, approaching the annual target of 37,590. Data quality improvements are ongoing, particularly with VCSE providers
  - Early Intervention: The rollout of Mental Health Support Teams (MHSTs) continues, with 31 teams now operational across all nine Places. However, a £3 million funding shortfall (including £2.7 million affecting MHSTs) has paused further expansion in 2025/26
  - Neurodevelopmental Pathway: The new pathway was launched in June 2025, with a focus on early identification, needs-led support, and integrated care. A risk stratification framework has been embedded in all Trust contracts
  - Crisis and Complex Needs: Work continues on developing crisis alternatives and appropriate places of care, though delivery is challenged by funding constraints and workforce capacity
  - Governance and Planning: A strategic review of MHSTs and a best practice model for community eating disorder services are underway. The Positive Behaviour Support pilot is progressing to procurement

  Member heard how the plan remains aligned with national priorities and local strategies, with oversight provided by the CYP Emotional Wellbeing and Mental Health Programme Partnership. The Committee noted the report

- received a report on the current position and future planning for Mental Health Teams in Schools (MHSTs) across Cheshire and Merseyside. As of Q4 2024/25, 31 MHSTs are operational, covering 54% of schools and colleges. These teams play a vital role in early intervention and whole-school approaches to mental wellbeing. Committee members were informed that despite a £3 million shortfall in CYP mental health funding, NHS England expects four new MHSTs to be launched in 2025/26. However, due to financial constraints, NHS Cheshire and Merseyside has not approved funding for Waves 13 and 14. A strategic review is underway to assess current coverage, impact, and workforce capacity, with the aim of achieving 100% coverage by 2029/30. The Committee noted the report and endorsed continued development of MHSTs and supported the need for a financial recovery and rollout plan to maintain momentum and meet national ambitions.

Assure

n/a

The next meeting of the Committee is scheduled for **13 August 2025.**

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

Highlight report of the Chair of the Shaping Care Together Joint Committee

Agenda Item No: ICB/07/25/14

Report approved by: Prof. Hilary Garratt, ICB Non-Executive Member

NHS
Cheshire and Merseyside

Highlight report of the Chair of the Shaping Care Together Joint Committee

Committee Chair	Prof. Hilary Garratt
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	04 July 2025

Key escalation and discussion points from the Committee meeting

Alert

-

Advise

At its meeting on the 04 July 2025 the Committee considered the following.

Shaping Care Together Pre-Consultation Business Case
The Shaping Care Together Pre-Consultation Business Case was considered by the Joint Committee. The Committee **decided to approve the Pre-Consultation Business Case (PCBC)**, with an amendment to ensure a commitment to provide sufficient urgent care services for the populations of West Lancashire or Sefton, dependant on which option is taking forward in the decision-making case. This was an action for both ICBs.

There was also a clarification change recommended in the document, with the space required for the Southport option verified to be 1789m^2 and therefore the cost to be £33m.

Shaping Care Together draft consultation document
The Committee also considered the proposed consultation document, associated material and timelines regarding the consultation with the public and stakeholders regarding the options within the PCBC. **The Committee approved the commencement of the consultation,** with the caveats replicated as above with regards to amendments on the commitment to provide sufficient urgent care services, and the clarification on the Southport option.

It was agreed that the consultation would go live during the afternoon of 04 July 2025, for a 13 week period. Details regarding the consultation would be published on both ICB websites which would direct people to the dedicated Shaping Care Together website https://yoursayshapingcaretogether.co.uk/

Assure

Programme Governance and future reporting
Programme governance and reporting was noted, with the addition of triple AAA reports to be reported from the SCT Programme Board into the Joint Committee.

Triple AAA reports to be reported from the SCT Programme Board into the Joint Committee.

Key programme timelines
Programme timelines were noted, being clear that no decisions had been made yet. Following the public consultation, the Joint Committee is expected to meet again in November (tbc).

Date of Next Meeting: November 2025

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

Highlight report of the Chair of the North West Specialised Services Joint Committee

Agenda Item No: ICB/07/25/14a

Committee Chair: Dr Ruth Hussey, ICB Non-Executive Member

NHS
Cheshire and Merseyside

Highlight report of the North West Specialised Services Joint Committee

Committee Chair	Dr Ruth Hussey
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	05 June 2025

Key escalation and discussion points from the Committee meeting
Alert
• No bids were received for the Adult Critical Care Transport Service provider selection process and further work will be undertaken to consider how to secure this service. The provider of the interim service in GM and LSC has recently appointed administrators – work underway to understand the implications of this
Advise
• NHS England has delayed the transfer of Specialised Commissioning staff to host ICBs in England until ICBs have merged (in other parts of England) and there is sufficient bandwidth for HR processes – anticipated towards end of 25/26. Work is being undertaken nationally to review the roadmap for integrating NHS England's Direct Commissioning functions into Integrated Care Systems in light of announcement of abolition of NHS England. • A Provider Selection process will be undertaken to secure provision in the NW for complex terminations of pregnancy. Currently patients requiring this service typically travel to Birmingham or Newcastle.
Assure

Committee risk management, reporting and escalation

The following risks with a score of 16 and above were reported to the Committee in accordance with the agreed Specialised Commissioning risk management, reporting and escalation Standard Operating Procedure.

Risk Title
1. Risk of patient harm as a result of non-delivery of cancer waiting time standards for specialised cancer surgery/chemotherapy/radiotherapy 2. Poor recovery of neurosciences activity, including spinal surgery, could lead to patient harm. 3. Cardiac Surgery: Poor recovery of activity could lead to patient harm 4. Non-Surgical Oncology - delays in move to a single service in Lancashire and South Cumbria is impacting on delivery of Chemotherapy waiting times which lead to harm. 5. Paediatric Surgery: Poor recovery of activity could lead to patient harm 6. Risk that premature babies will have avoidable lifetime visual disability due to lack Retinal screening in neonatal units across the NW 7. Patients are unable to access mechanical thrombectomy at in Lancashire and South Cumbria out of hours and at weekends as the Lancashire Teaching Hospitals NHS Foundation Trust is unable to offer a weekend and out of hours service. 8. Avoidable inequalities, poor outcomes and harm associated with none compliance with neonatal critical care service standards: • NHSE Service Change Assurance Process Gateway 2 being further delayed for NW Safe and Sustainable Services (SAS) for Babies & Children's Transformation Programme • Risk of challenge against NW SAS Babies & Children's Transformation Programme 9. The following 2 risks relate to the development of the Commissioning Hub: • The hub is unable to provide a safe and effective service as set out in the Target operating model for Delegated Service Commissioning. • Due to the number of vacancies within the finance team, unless there is the ability to recruit to the retained and delegated staff vacancies, there is not the critical mass to have separated NW delegated and a North retained finance teams from 1 July 2025.

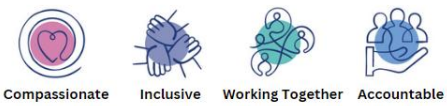
Specialised Commissioning Programmes and Areas of Focus

Service Programme / Focus Area	Key actions/discussion undertaken
Regional Director Update	Andrew Bibby (AB) provided an update on several topics, including the delay in transferring specialised commissioning staff, the impact of the abolition of NHS England, the last-minute changes to the 25/26 contracting round, and the funding of new drugs and linear accelerators. AB discussed the development of a paper on mental health lead provider collaboratives, which will explore options for future configurations and the financial arrangements for these collaboratives. Action: AB to find out the financial impact (savings or costs) of the new drugs for the North West and report back.
ICB update	Craig Harris, Clare Watson, and Katherin Sheerin provided updates on their respective ICBs, discussing their work on commissioning and structural arrangements, the integration of specialised commissioning, and the challenges they are facing.
Items for decision/endorsement	**Complex Termination of Pregnancy:** The paper has been shared and comments incorporated. There is general support for the procurement approach, with some clarification needed on phases. Funding use is fixed, and cost concerns around management fees will be addressed. The committee supported proceeding with the procurement. **Adult Critical Care Transfer Procurement:** Carole Hodgkinson (CHo) discussed the challenges faced in the procurement process for adult critical care transfer services. Despite initial interest, no bids were received due to uncertainties and risks in the current climate. The team plans to gather more detailed information and extend current interim services. Action: Carole Hodgkinson to provide a SBAR to Katherine Sheerin by 9th June, to ensure Chief Officers are kept informed of the ER Systems Medical situation.

Service Programme / Focus Area	Key actions/discussion undertaken
Quality roles & responsibilities	Sue McGorry (SM) presented the quality roles and responsibilities, highlighting the importance of governance and assurance. She mentioned the need for flexibility in roles and responsibilities due to the current environment. The quality roles and responsibilities have been shared and developed in conjunction with the quality leads from each of the ICBs, ensuring a collaborative approach.
Finance Update	Carol Stubley (CS) provided an update on the finance team's challenges, including a 50% vacancy factor and the need to prioritise work. She mentioned the importance of working closely with ICBs to manage financial risks. The team is operating in business continuity mode, which means moving from monthly to quarterly reporting for some areas and prioritising deep dives based on materiality and risk. CS acknowledged the need to contribute to the three-year financial plan, despite current resource constraints, and highlighted the importance of rebasing blocks and considering efficiency measures.
Risks	Carole Hodgkinson presented the risk paper, highlighting continued monitoring of high-risk specialties like neurosurgery, gynaecology, and skin cancer. She noted the need to review waiting list risks under current planning and confirmed a detailed update will follow. A new risk has been added regarding GMMH and adult forensic provider arrangements due to financial concerns with GM Provider Collaborative. The recent cardiac summit was seen as positive, with proposed actions for cardiac surgery and ongoing scoping work for skin cancer capacity. She also outlined extensions to target dates for some risks, including staffing and women's and children's services, due to ongoing restructuring.

Service Programme / Focus Area	Key actions/discussion undertaken
Focus on: Women's and Children's Programme of Care	Andrew Bibby (AB) and Fiona Simmons-Jones (FSJ) gave an overview of the women's and children's programme, outlining key risks, performance concerns, and current areas of focus. FSJ emphasised prevention opportunities, highlighting modifiable health behaviours and wider determinants such as housing and immunisation uptake. AB discussed neonatal services, noting the need for a surgical unit at Alder Hey and concerns about the limited capacity at Macclesfield's special care baby unit and also highlighted challenges in children's surgery recovery post-pandemic, especially at District General Hospital level, and stressed the need for a strategic approach. Poor recovery in specialised gynaecology, particularly complex endometriosis, was also noted, with calls for targeted intervention.
Acute Specialised Service Priority Focus Areas	The paper outlined a co-produced approach to developing the priority list, involving engagement with ICB colleagues, networks, cancer alliances, and other stakeholders. The paper was approved.
Health Inequalities Update	A paper on the formation of the NW specialized commissioning Health inequalities Group andproposed initial priorities was provided for information. A more comprehensive update will be provided at the September meeting
ICB Blueprint	Andrew Bibby noted a workshop is planned for late June between the specialised commissioning team and the three executive leads with the aim to review the specialised target operating model in light of the ICB blueprint.

NHS
Cheshire and Merseyside



Leading integration through collaboration

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

Highlight report of the Chair of the Women's Hospital Services in Liverpool Committee

Agenda Item No: ICB/07/25/14**b**

Committee Chair: Prof. Hilary Garratt, Non-Executive Member

Highlight report of the Chair of the Women's Hospital Services in Liverpool Committee

Committee Chair	Hilary Garratt
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	15th May 2025

Key escalation and discussion points from the Committee meeting
Alert
N/A
Advise
The Committee considered the following at its meeting in May 2025: **LWH Maternity and Gynaecology Prevention and Equity Population Profile 2023-24 Summary** Clare Baker presented the Liverpool Women's Hospital Maternity Gynaecology Prevention and Equity Population profile summary which was created to get an understanding of the needs of the population to inform the programme and service design. LWH users of services who live in the top 40% least deprived areas in the country and people who are white British, make up just 10% of maternity patients and 20% of elective gynaecology patients. The clinical care model therefore needs to be designed to focus on the needs of the majority who come from more deprived and challenged backgrounds. This report can be viewed in Appendix One to this report. **The Committee acknowledged and noted the equalities report.** **Options Appraisal Process** The committee received feedback from workshop 1. It was valuable to have lived experience panel members at the workshop, which brought a very different perspective to the conversation. Clinicians were engaged and present with good representation from across the system. It was a positive workshop, with genuine impact and appetite to move on to the next stage. More evaluation criteria have been included regarding safe and effective care and patient access and experience. Acceptability criteria have been removed as these were judged to be too subjective. The evaluation criteria have been shared with the Clinical Reference Group for further feedback. **The Committee –** • **Noted the update from 1 May 25 Workshop.** • **Approved the final hurdle criteria and evaluation criteria for Workshop 2.**

- **Provided feedback on the draft long list.**
- **Were assured that due process was being followed in the option appraisal process.**

Assure

The Committee considered the following at its meeting in May 2025:

Programme Update

The Chair of the Programme Board provided an update which included -

Options Appraisal Workshop 1 took place on 1 May 25 where draft hurdle criteria, draft evaluation criteria and draft long list were tested, and amendments agreed. 52 people attended, including 5 members from the Lived Experience Panel, 2 representatives from local voluntary sector organisations and Healthwatch Liverpool.

The Clinical Leaders Group met to agree the final changes to criteria and long list.

Additional capacity from MIAA has been secured to support the modelling work.

An equalities analysis of the public engagement exercise was completed; this has provided insights that should improve the effectiveness and reach of any future programme engagement.

A Prevention and Equity Population Profile of the users of LWH maternity and gynaecology was produced. Information from this profile will be included in the case for change in any future business case. It will also be used to inform the future model of care.

Lived Experience Panel recruitment was re-opened and new members have joined the panel, some of whom joined Workshop 1.

A new risk has been added to programme risk register regarding the requirement for NHS organisations to make staff reductions in 2025/26, which could impact on the ability to deliver the programme.

Through the Deteriorating Patient Collaborative, the gynaecology and maternity teams are continuing to improve use and reliability of early warning scores.

All actions required following the unannounced CQC inspection at the end of April 2024, and the Maternity Support Programme, are now delivered and embedded. Formal feedback is awaited.

The Committee noted the programme update and progress made since the last meeting.

Equalities Review of the Public Engagement Report

Andy Woods presented the second interim equalities report (the first one was completed on the case for change) highlighting the need to be cognisant of the public sector equality duty throughout the process, particularly given some poor outcomes across women's and maternity services nationally. This equalities report provides a steer for future engagement and/or formal consultation noting where the focus should be on disadvantaged groups.

The Lived Experience Panel has been opened up to new members; 30 people initially expressed an interest last summer and of those 15 members have been involved in meetings. Some new members have now joined and took part in the first options workshop. Recruitment for new members will be kept open.

The Committee –

- **Acknowledged and noted the equalities report.**
- **was assured of the statutory delivery of equalities duties.**

Programme Risk Register -

The programme risk register has been updated with new actions.

- Risk 6 – onsite quality and safety – the LWH team has made great progress over the last twelve months, and the score could be brought down, this will be discussed at Programme Board on 21 May 2025.
- Risk 7 – a new risk has been added regarding staff reductions in the NHS and the potential impact on the programme. The programme budget has been agreed, however as the staff reductions are made throughout the year, there could be implications for the programme.

The Committee noted the update on the programme risks including the new risk regarding staff reductions.

Appendices

Appendix One: Liverpool Women's Hospital Prevention and Equity Population Profile 2023-24

University Hospitals of Liverpool Group

Liverpool Women's Hospital Maternity and Gynaecology Prevention and Equity Population Profile 2023-24 Summary

Understanding our patient population helps us design and deliver services that achieve our quality ambitions for every patient, irrespective of their background, characteristics and the conditions in which they live.

There is a significant difference between demographics and experiences common among senior decision-makers and common among our patients. Designing services for the white and well-off would focus on about 10% of our maternity and emergency gynaecology patients.

50-75% of our patients have at least 1 risk factor for health inequalities. Health inequalities are defined as worse health due to unfair, avoidable and systematic differences. In healthcare, this may mean worse access, experience, safety or outcomes. The most vulnerable will be those for whom multiple factors combine.

Core20 = 20% most deprived

64% of maternity bookers

71% of emergency gynaecology admissions

52% of elective gynaecology admissions

Ethnic minorities (based on those with recorded data)

29% of maternity bookers

26% of emergency gynaecology admissions

14% of elective gynaecology admissions

16% of gynaecology outpatient attendances

People with additional or diverse needs and people dealing with adverse life experiences accessing our services are common events.

For example, an average month at LWH sees

- 29 admissions of someone with a recorded diagnosis of autism or learning disability
- 44 new internal referrals, 52 police notifications and 263 MARAC research requests received by the LWH Safeguarding Team, all relating to domestic abuse

This context means our patient population experience high levels of preventable clinical risk that we need to prevent, mitigate and plan for.

Health literacy

47% of people aged 16-65 in Liverpool are likely to have difficulties understanding or interpreting health information

Obesity and comorbidities

20-25% of maternity bookers had a BMI 30-35

8.68% of deliveries were to women with gestational diabetes

24.3% of women in Liverpool aged 20+ have multimorbidity (≥2 long-term conditions in the QOF register), varying significantly by age

Available local and national projections to 2040 suggest small increases in patient catchment population but significant increases in complexity affecting both maternity and gynaecology due to increasing age and comorbidities

Liverpool Women's Hospital Prevention and Equity Population Profile 2023-24

Date: 4 April 2025

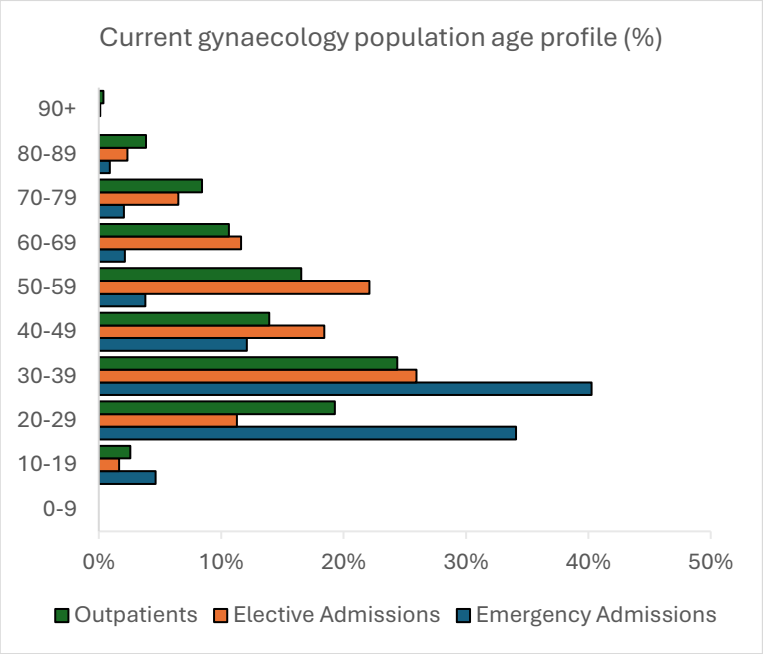
Author: Dr Clare Baker, Public Health Registrar

Introduction

This profile aims to understand the key characteristics of the patient population using Liverpool Women's Hospital (LWH) services in 2023-24 in relation to health inequalities and major preventable risks affecting patient care and outcomes. This understanding will inform service planning and delivery, supporting delivery of our quality ambitions for every patient, irrespective of their background, characteristics and the conditions in which they live. The profile focuses on maternity and gynaecology services to align with and inform the Improving Hospital Gynaecology and Maternity Services in Liverpool programme led by NHS Cheshire and Merseyside.

1. Who uses our services?

Women of all ages use LWH gynaecology services. **Women of reproductive age (aged 15-49) made up 91% of emergency gynaecology admissions. Elective and outpatient services had a broader peak across women of menopausal and reproductive age. 71.5% of deliveries were in women aged 25-36.**



Women living in Liverpool local authority area formed the largest proportion of patients (65% of deliveries and 52% of gynaecology admissions). Next were women from Sefton (16% and 19%), Knowsley (9% and 9%), other parts of Cheshire and Merseyside (6% and 12%) and areas outside Cheshire and Merseyside (3% and 7%). The proportions are different for gynaecology cancer services, in which 57% were from Liverpool, Sefton and Knowsley and 43% from other areas.

2. Which patient groups are at risk of worse outcomes because of unfair and avoidable differences?

Health inequalities are defined as avoidable, unfair and systematic differences in health between different groups of people[1]. In healthcare, this means people may have worse access, safety, experiences and outcomes. Reasonable adjustments could avoid or reduce these differences.

There is no single dataset that measures all the factors needed to assess risk of health inequalities. Therefore, this profile examines different factors relevant to the LWH patient population in turn. **The most vulnerable will be those for whom multiple factors combine.**

Based on recorded ethnicity and deprivation alone, **70%** of maternity bookers **75%** of emergency gynaecology admissions **50%** of elective gynaecology admissions have **at least 1 risk factor** for healthcare inequalities	**Core20** 64% of maternity bookers 71% of emergency gynaecology admissions 52% of elective gynaecology admissions live in the 20% most deprived areas in the country
Ethnic minorities* 29% of maternity bookers 26% of emergency gynaecology admissions 14% of elective gynaecology admissions 16% of gynaecology outpatient attendances **based on those with recorded data = 84%M, 88%EmG, 89%ElG, 88%OPG*	**Primary language other than English*** 16% of maternity bookers 14% of emergency gynaecology admissions 5% of elective gynaecology admissions 6% of gynaecology outpatient attendances **based on those with recorded data = 91%M, 99%EmG, 97%ElG, 95%OPG*

Ethnicity and deprivation data alone indicate that **the norm among our patient population is to be at risk of unfair and avoidable differences requiring consideration of reasonable adjustments**. The differences between senior decision-maker populations and our typical patient population emphasise how important adjusting our understanding of the norm is. It is well-recognised nationally that people who are White British and well-off (eg. living in the 40% least deprived areas in the country) are typically disproportionately represented in senior decision-maker roles. However, they were the minority among our patients, making up just 9-10% of maternity bookers and gynaecology emergency admissions.

Almost two thirds of maternity bookers lived in the 20% most deprived areas in the country. Our partner hospitals in Liverpool University Hospitals Trust ranked in 2020 (the

[1] NICE. NICE and health inequalities. 2025. Available here

latest available data) as having the most deprived catchment population of any acute trust[2]. Specialist trusts are excluded so LWH is not ranked.

Missing data is more of a challenge for ethnicity and language, but where recorded, **one in four maternity bookers is from an ethnic minority group and one in six has a primary language other than English.** The term ethnic minorities refers to all ethnic groups except the White British. The lower proportions of patients from ethnic minorities and living in deprivation accessing elective and outpatient gynaecology services likely result from a combination of differing geographical patient distributions, differing age profiles and fertility rates in differing populations and potentially unmet elective care needs in some groups because of inequalities.

Diverse or additional needs

Every month at LWH (Apr-Oct 24)

18 admissions of people with autism

11 admissions of people with a learning disability

10 people are referred to the Safeguarding Team for significant mental health concerns

Other factors that can mean people are at increased risk of experiencing healthcare inequalities include other protected characteristics, diverse and/or additional needs and adverse life experiences, both in childhood and adult life. Available data (Apr-Oct 2024) indicates that **on average someone with a recorded diagnosis of autism or learning disability is admitted to LWH every day** (29 admissions per month). On average every 3 days, someone is referred to the LWH Safeguarding Team because of significant mental health concerns (10 referrals per month). Looking forward, roughly 1 in 6 girls in the last Liverpool Schools Census (2023/24) were recorded as having Special Educational Needs[3]. This is a broad category with variable implications for how people will access and experience healthcare, but is an indication of the population who will be the maternity and gynaecology patients of the future.

Of the available data on adverse life experiences affecting women attending LWH, the data on violence against women and girls stands out starkly. **An average month in the LWH Safeguarding Team will see 44 new internal referrals, 52 police notifications and 263 MARAC research requests received by the LWH Safeguarding Team, all relating to domestic abuse.** The national and local data on violence against women and girls is context for Lived Experience Panel and community feedback to the Improving Hospital Gynaecology and Maternity Services in Liverpool programme that a feeling of safety is crucial when accessing maternity and gynaecology services. A recent report from Healthwatch Liverpool and partners describes some of the impacts previous experiences

[2] Office for Health Improvement and Disparities. NHS Acute (Hospital) Trust Catchment Populations: 2022 Rebase Experimental Statistics. 2022. Available here.

[3] Liverpool City Council Public Health. Women's Health JSNA [unpublished analysis].

of sexual assault can have on future healthcare engagement, particularly when intimate procedures are involved, as is often the case for maternity and gynaecology.[4]

Domestic abuse referrals at LWH	**Violence against women and girls: National and local context**
Every month at LWH (Apr-Oct 24), the LWH Safeguarding Team received 44 internal referrals 52 police notifications 263 MARAC research requests	The Home Office estimate that in the UK, in her lifetime, 1 in 4 women will experience domestic abuse 1 in 5 women will experience sexual assault Liverpool's annual police recorded sexual offences rate is 1.5x the national average and 80% of victims are women

This profile cannot cover all relevant factors. Currently available data for as many characteristics as possible is summarised in appendix 2.

3. What are the major preventable clinical risks in our patient population?

The conditions in which people are born, grow, live, work and age and the inequalities in them, some of which were described in section 2, **influence health behaviours, further increasing health inequalities**. Therefore, the characteristics of our patient population influence the patterns of preventable clinical risk that LWH must plan for and manage and increases the importance of our role in prevention. This section of the profile presents selected major patterns of clinical risk affecting maternity and gynaecology services.

Health literacy

47% of people aged 16-65 in Liverpool are likely to have difficulties understanding or interpreting health information

Low health literacy is a significant risk as it influences the other risks people take in terms of health behaviours and affects how, when and where people access healthcare. Examples in maternity and gynaecology include late booking of pregnancies, low uptake of HPV vaccination and cervical screening and late presentations of gynaecological cancers. **Half of adults aged 16-65 in Liverpool (47.4%) are likely to have difficulties understanding or interpreting health information, rising to two-thirds (67.5%) if the information contains numbers**[5].

LWH patients continue to be adversely affected by the risks of smoking and the risks of unprotected sex in terms of sexually-transmitted infections and unwanted pregnancies.

[4] Healthwatch Liverpool. The impact of Sexual Trauma on attendance for health appointments. 2024. Available here.
[5] University of Southampton. Health Literacy: Prevalence Estimates for Local Authorities. 2025. Available here

9.4% of LWH bookers and intrauterine transfers smoke. Liverpool's abortion rate is higher than the national average and increasing at a faster rate (2012-2021 data)[6].

The LWH patient population experiences high rates of obesity[7] and other comorbidities[8]. Obesity carries significant clinical risks in maternity and gynaecology services, including increased symptoms (eg. with dysmenorrhoea) and increased complication rates (eg. gestational diabetes, anaesthetic complications, wound infections). Severe obesity may require specific equipment or services.

Obesity and comorbidities

20-25% of maternity bookers had a BMI 30-35

8.68% of deliveries were to women with gestational diabetes

24.3% of women in Liverpool aged 20+ have multimorbidity (≥2 long-term conditions in the QOF register), varying significantly by age

Intergenerational transfer of risk

9.0% of babies were born prematurely (<37 weeks)

10.9% of term babies were born small for gestational age

Inequalities are further entrenched by transfer of preventable risk between generations. In maternity, this is particularly seen in preventable neonatal risks, which include a significant proportion of prematurity and babies born small for gestation age.

4. What should we expect in the future?

The Office for National Statistics (ONS) provides population projections for local authority areas based on mid-year population estimates and current assumptions of future fertility, mortality and migration[9]. If the projected changes for Liverpool by 2040 were seen across the whole LWH catchment population, the age profile of current care use suggests this population change alone would lead to a 3% increase in emergency gynaecology admissions, and 5-6% increases in elective gynaecology admissions and gynaecology outpatient appointments. However, two thirds of the increase in elective and outpatient gynaecology (an additional 169 admissions and 2561 appointments) would be in the 70+ group, meaning an **increase in age-related complexity in gynaecology.**

ONS Projected Population Change in Liverpool between 2023 and 2040

6% increase in the number of people aged 0-19

2% increase in the number of people aged 20-69

34% increase in the number of people aged ≥70

ONS's estimate based on 2021 assumptions is that across the UK there will be a 6% increase in the total number of births per year by 2040[10]. Their projections show a marked

[6] Liverpool City Council Public Health. Women's Health JSNA [unpublished analysis].
[7] NHS England. National Maternity Dashboard. 2024. Available here
[8] Liverpool City Council Public Health. Women's Health JSNA [unpublished analysis].
[9] Office for National Statistics. Population projections for local authorities. 2020. Available here
[10] Office for National Statistics. National population projections: 2021-based. 2024. Available here

change in age profile of women at delivery, indicating an **increase in age-related complexity in maternity.**

ONS projected change in mother's age at delivery in the UK between 2023 and 2040

62% reduction in mothers aged 15-19

23% reduction in mothers aged 20-24

2% increase in mothers aged 25-29

1% increase in mothers aged 30-34

23% increase in mothers aged 35-39

81% increase in mothers aged 40+

National projections for obesity and comorbidities have been estimated by extrapolating current trends in these conditions. Cancer Research UK estimate that, if trends to 2019 continue, there will be a 27% increase between 2019 and 2040 in women in England with a BMI≥30, an increase disproportionately affecting people living in deprived areas[11]. The Health Foundation estimates that, if current trends continue, there will be a 37% increase between 2023 and 2040 in the number of people living with major illness (at least 2 long-term conditions in the QOF register)[12]. LCC Public Health project that the long-term condition that will experience the biggest increase in prevalence in Liverpool is depression[13]. **If recent trends continue, LWH would see further significant increases in complexity in maternity and gynaecology due to obesity and comorbidities.**

Conclusion and recommendations

Conclusion

We must acknowledge the gap between demographics and experiences common among senior decision-makers and common among our patients. Designing services for the white and well-off would focus on about 10% of our patients.

50-75% of LWH maternity and gynaecology have at least one risk factor for worse outcomes due to health inequalities. Delivering our quality ambitions for all patients therefore involves service design that responds to our patient population needs and embeds a robust approach to reasonable adjustments that reduce health inequalities.

Available local and national projections to 2040 indicate small increases in patient population but large increases in complexity affecting both maternity and gynaecology due to increasing age and comorbidities. Prevention is critical to reducing this future burden as well as being a key tool in reducing inequalities.

[11] Cancer Research UK. Overweight and obesity prevalence projections for the UK, England, Scotland, Wales and Northern Ireland, based on data to 2019/20. 2022. Available here

[12] The Health Foundation. Health inequalities in 2040: current and projected patterns of illness by deprivation in England. 2024. Available here

[13] Ashton M et al. State of Health in the City: Liverpool 2040. 2024. Liverpool City Council. Available here

Recommendations

For the Hospital Gynaecology and Maternity Services in Liverpool programme

A sustainable future model of care that responds to the programme's Case for Change should also

1. **Be informed by the best available projections of future patient needs,**
   1.1. Considering the equipment, services and multi-disciplinary arrangements needed to prepare for future projections of small increases in overall patient population size but significant increases in complexity
   1.2. Supporting the embedding and mainstreaming of preventive approaches
2. **Support access for our most vulnerable patients including,**
   2.1. Creating a feeling and space of safety for women accessing intimate care
   2.2. Delivering a simple model and public communications that makes it easy for patients with low health literacy to know when, where and how to access care
   2.3. Minimising indirect costs to the patient of accessing care (eg travel costs, time off work), particularly considering options for outreach offers to bring care closer to the patient and one-stop offers to minimise repeat visits

For Liverpool Women's Hospital to respond to health inequalities and prevention

1. **Strategic leadership and effective governance**
   1.1. Add health inequalities to the LWH corporate risk register as a major preventable cause of worse patient outcomes and of clinical complexity
   1.2. Agree equity as a dimension of quality and therefore to be considered in existing quality standards and improvement processes
   1.3. Explore an LWH Prevention and Health Inequalities Group to develop and implement a prevention and health inequalities plan aligned with the forthcoming UHLG strategy
2. **Data and reporting**
   2.1. Integrate this profile's approach to understanding our patient population into business as usual internal data reporting processes
   2.2. Explore data processes for understanding health inequalities in key performance indicators by ethnicity and deprivation
3. **Create capacity and awareness for the response**
   3.1. Share this report and/or the accompanying slides with staff at all levels of LWH
   3.2. Explore options to establish sustainable capacity to develop and deliver a population needs-informed prevention and health inequalities plan
4. **Innovate and pilot new programmes responding to key inequalities**
   4.1. Become a pilot site, focussing on maternity, for the NHSE North West Health Literate Organisation programme (beginning April 2025)
   4.2. Be a pilot site for #CheckWithMeFirst, supporting trauma-informed care

Appendix 1: Methods and Acknowledgements

Methods

The profile uses Liverpool Women's Hospital data for the last full April-March year, 2023/24. Where this was not possible, other available timeframes were first alternative. Other relevant populations, such as local authority or national populations, were second alternative. Project timescales meant only already extracted and aggregated data requiring no or minimal initial analysis could be included.

Groups considered in question 2 were drawn from the NHS Core20Plus approach to health inequalities and checked against the Women's Health Strategy for England, the Women of the North report and the Liverpool Women's Health Joint Strategic Needs Assessment (in progress). Groups with available data and most relevant to the patient population at Liverpool Women's Hospital were chosen for inclusion in this initial profile.

Risks in question 3 were prioritised for inclusion based on the available evidence base and informed by discussion with lead clinicians at Liverpool Women's Hospital.

Acknowledgements

My thanks to all those at Liverpool Women's Hospital (LWH) who advised on the development of this profile. Particular thanks go to Hayley McCabe (Information and Performance Manager, LWH), Deborah Ward (Head of Safeguarding, LWH) and Sophie Kelly (Lead Public Health Epidemiologist, Liverpool City Council) for their support accessing data.

Appendix 2: At risk groups profile

Table. LWH Population Profile Summary by groups at risk of health inequalities displaying most recent available data for LWH, or closest available single indicator by local authority, as at December 2024

* = % where data recorded, † = April-October 2024 data, ‡ = 2021 census data, ¶ = unpublished LCC Women's Health JSNA, § = https://healthliteracy.geodata.uk/

Group (people who...)	LWH data (2023/24)			Local authority prevalence		
	Maternity Bookers	Emergency Gynae Admissions	Elective & Outpatient Gynae	Liverpool	Sefton	Knowsley
Live in the Core20 (most deprived)	64%	71%	52% (elective admissions)			
Are of ethnic minority backgrounds*	29%	26%	14% (elective admissions) 16% (outpatient attendances)	5.7% Asian or Asian British 3.5% Black, Black British, Caribbean or African 3.5% Mixed or multiple ethnic groups 3.3% Other ethnic groups 6.7% White minority groups including 0.2% Roma and 0.1% Gypsy or Irish Traveller ‡	1.5% Asian or Asian British 0.5% Black, Black British, Caribbean or African 1.5% Mixed or multiple ethnic groups 1.5% Other ethnic groups 4% White minority groups ‡	1.6% Asian or Asian British 0.8% Black, Black British, Caribbean or African 1.7% Mixed or multiple ethnic groups 0.6% Other ethnic group ‡
Have a primary language other than English*	16%	14%	5% (elective) 6% (outpatient)	9.6% of residents, 24.3% of whom cannot speak English well or at all ‡	3.6% of residents, 24.3% of whom cannot speak English well or at all ‡	3.0% of residents, 20.2% of whom cannot speak English well or at all ‡
Identify as LGB+				4.7% of women ‡	2.5% of residents ‡	2.3% of residents ‡
Identify as transgender				0.7% of residents ‡	0.3% of residents ‡	0.2% of residents ‡
Are neurodiverse	18.2 admissions per month (any specialty) †					
Have a learning disability	10.7 admissions per month (any specialty) †					
Have a disability				23.0% (self-identified) ‡		
Have a sensory impairment				7.3% of women aged 18+ have some hearing loss ¶		
Have a significant mental health condition	10.0 referrals per month to the LWH Safeguarding Team because of significant mental health concerns (any specialty) †			22.1% aged 18+ have a diagnosis of depression ¶		
Have dementia	1.2 admissions per month (any specialty) †			0.77% of women aged 18+ ¶		

Are a victim of domestic abuse	43.5 internal referrals, 52.8 police notifications, 263.2 MARAC research requests per month to the LWH Safeguarding Team relating to domestic abuse (any specialty) †			1904 cases referred to MARAC in 2022/23 ¶		
Are a victim of sexual abuse/assault (note this data does not capture impacts of non-recent abuse)	4.3 referrals per month to the LWH Safeguarding Team relating to sexual abuse (any specialty) †			3.8 sexual offences per 1000 population in 2022/23, of which about 80% of victims are women ¶		
Are experiencing homelessness	3.8 referrals per month to the LWH Safeguarding Team relating to homelessness (any specialty) †					
Have a substance misuse problem	8.5 referrals per month to the LWH Safeguarding Team relating to substance misuse (any specialty) †			1512 women in drug and alcohol treatment services in 2022/23 ¶		
Are a vulnerable migrant (eg seeking asylum or are a refugee)				0.61% of total population ¶		
Are a victim of modern slavery	2.7 referrals per month to the LWH Safeguarding Team relating to modern slavery (any specialty) †					
Are in or have experience of the care system				172 per 10,000 children in care in 2022 ¶		
Are an unpaid carer				11.5% of women (self-reported) ‡		
Are engaged in sex work						
Have experience of the criminal justice system				368 women in probation services in 2024 ¶		
Have low health literacy				47.4% of adults aged 16-65 67.5% if information includes numbers §	41.8% of adults aged 16-65 61.0% if information includes numbers §	48.8% of adults aged 16-65 68.6% if information includes numbers §
Other.... (groups not captured here that may be considered include those relating to marriage or civil partnership, those relating to religion and belief, people who live in remote rural and island communities, and military veterans and their families)						

NHS
Cheshire and Merseyside

Meeting of the ICB Board of NHS Cheshire and Merseyside

Intensive and Assertive Community Mental Health Care Update - Response to the Independent investigation into the care and treatment provided to VC

Agenda Item No: ICB/07/25/15

Responsible Director: Simon Banks, Place Director (Wirral) and Strategic Lead for Mental Health, Learning Disabilities and Autism

Intensive and Assertive Community Mental Health Care Update - response to the Independent investigation into the care and treatment provided to VC

1. Purpose of the Report

1.1 This report provides an update to the action plan presented to the Board in November 2024 regarding Intensive and Assertive Community Mental Health Care.

1.2 The update includes additional actions from the recommendations of the Mental Health Independent Investigation Report[1] published by NHS England on the 5th February 2025 into the tragic deaths of Barnaby Webber, Grace O'Malley-Kumar and Ian Coates who lost their lives in Nottingham in June 2023.

1.3 The independent report highlights instances where Mr Valdo Calocane (VC), a patient experiencing serious mental illness, was failed by mental health services, which had devastating consequences.

2. Executive Summary

2.1 As a first step in improving care to those people experiencing serious mental illness NHS England included a requirement in the 2024/25 operational planning guidance[2] that all ICBs "review their community services by quarter 2 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge".

2.2 A presentation, paper and action plan were presented to the Board in November 2024[3] providing an overview of the gaps in provision identified against the published guidance regarding the ability to comprehensively identify, maintain contact and meet the needs of people who require intensive and assertive community mental health care and follow-up. The action plan outlined short-term actions with minimal resource implications, as well as potential longer-term actions, which had resource implications.

2.3 Following the publication of the independent investigation NHS England has requested that this action plan is updated in line with ICB commitments to keep

[1] Mental Health Independent Investigation Report into the care and treatment of VC
[2] NHS England » Priorities and operational planning guidance 2024/25
[3] https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/nhs-cheshire-and-merseyside-integrated-care-board/2024/28-november-2024/

this under regular review, and ensure that it addresses the issues identified in the independent review with particular attention to:

- personalised assessment of risk across community and inpatient teams
- joint discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved agencies)
- multi-agency working and information sharing
- working closely with families
- eliminating Out of Area Placements in line with ICB 3-year plans.

2.4 Since the issue of the initial planning guidance and presentation of action plans to the ICB Board in November 2024;

- work has continued in both mental health trusts on the short-term actions with minimal resource implications. This is overseen by the Adult and Older Adult Community Mental Health Oversight Group. Appendix one provides an overview of progress to date

- NHS England has published a draft personalised care framework for adult community mental health services which further supports the work highlighted in the action plan and the homicide report. This is currently out for national consultation and includes 10 areas of focus

- in light of the recent tragic events that occurred in Southport, assurance has been sought from other mental health directorates for children and young people's MH services, secure mental health services and learning disability and autism services

- both NHS mental health providers have presented the findings from the homicide review at Trust Board level meetings and updated their action plans to address any gaps

- a further request has been received from NHS England to complete and return a review template by 3rd September 2025 detailing a RAG rated ICB self-assessment. A small panel is being convened to meet this requirement.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- Note the requirements from NHS England for this updated report and action plan to be presented to ICB Public Boards before the 30 June 2025. NHS England acknowledged that NHS Cheshire and Merseyside Annual Report and Accounts for 2024-25 were the single agenda item for June Board and agreed a revised timescale for July 2025

- Note the actions outlined in Appendix One that will need to be fully addressed to ensure that intensive community treatment and follow-up

can be provided

- Note that a progress update against actions was presented to the Cheshire and Merseyside Quality and Performance Committee on 10 July 2025:
  - the Committee queried the level of progress made by each of the MH providers and requested confirmation of the Mersey Care NHS Foundation Trust RAG status ahead of this Board meeting as progress appeared to be behind that reported by Cheshire and Wirral Partnership NHS Trust
  - Appendix One reflects a revised updated position compared with the report received by Quality and Performance Committee earlier this month and evidences that both trusts are on track with actions
  - the Committee noted the intention for monitoring to be via current Trust contract meetings with regular updates provided to the Cheshire and Merseyside Quality and Performance Committee
- Agree the frequency of updates to the NHS Cheshire and Merseyside Board
- Note the requirement for a further ICB self-assessment to be completed by 03 September 2025.

4. Reasons for Recommendations

4.1 Identification of gaps and mitigating actions is required to improve the care and treatment of individuals who require an intensive and assertive approach from mental health services, as mandated by NHS England and to address the specific areas highlighted in the independent homicide investigation.

5. Background

5.1 Many people who experience psychosis are able to receive evidence-based care and treatment which enables them to recover from their psychotic episode and/or be supported to live a life that is meaningful to them alongside the management of ongoing symptoms.

5.2 Some people who experience psychosis, particularly where paranoia is present, struggle to access evidenced-based care and treatment. This can be due to core services not being able to meet people's needs, the impact of symptoms such as paranoia or a lack of understanding from the individual that they are unwell. For this group of people, it is critical that mental health services are able to meet the person's needs by adapting the approach to engagement, providing continuity of care, and offering a range of treatment options for people

experiencing a varying intensity of symptoms.

5.3 People with these needs can be very vulnerable to harm from themselves and from others; for a very small number of people relapse can also bring a risk of harm to others. Integrated Care Boards (ICBs) have a duty to provide care and treatment in a way that meets the needs of this group. This does not have to be through a standalone team, but there should be dedicated provision in place within Community Mental Health Teams, or other specialist services, to support this population group.

5.4 Improving the care and treatment of individuals who require an intensive and assertive approach from health services is a priority for the NHS. National guidance[4] was published in July 2024, and this has been further reinforced by the publication of the mental health independent homicide investigation into the care and treatment of VC.

5.5 A number of barriers and challenges were identified to the provision of intensive and assertive community mental health care as described in the national guidance. These include;

- **Workforce**- Capacity and Resource e.g. gaps in specialist roles and specialist training, 24/7 service availability in Community MH Teams

- **Governance and Systems** – whilst escalation processes are in place, they are not specific to this vulnerable population. Limited monitoring systems are in place to identify people in local communities who may need this treatment approach

- Current **policies, legal frameworks, and insufficient system-wide guidance** contribute to the fragmentation of services, preventing a seamless, integrated approach to mental health care. There is a lack of a specific outcome framework for an Assertive Outreach approach

- **Finance and resource limitations** including the need for additional funding to address workforce gaps, support the extension of service hours, enhancement of roles, training, and digital gaps. In addition, funding for VCSFE partners to provide additional support.

[4] Guidance-to-integrated-care-boards-on-intensive-and-assertive-community-mental-health-care/

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

- Specific actions will be addressed to prevent barriers to access and reduce health inequalities for this population group. Local population mental health and physical health needs (including health inequalities) will be reviewed, existing support available will be mapped, and gaps in provision will be identified. Support will be aligned to the CORE20PLUS5 approach to reducing health inequalities.

Objective Two: Improving Population Health and Healthcare

- People with mental health problems such as psychosis are at increased risk of poor physical health and die on average 15 to 20 years earlier than the general population.

- Services will provide holistic care that is engaging, evidence-based and trauma informed. This is often a complex service-user group; therefore services should be well equipped to support people with co-occurring needs.

- A whole system approach will be adopted. Services will aim to ensure good integration exists across wider community teams, inpatient, and primary care as well as clear working protocols with housing, criminal justice, social care, local government, VCSFE, and substance misuse services. Fragmented care pathways which hinder effective care delivery will be addressed.

Objective Three: Enhancing Productivity and Value for Money

- Workforce will be equipped with the right skills and competencies to support this service user group ensuring that they can respond to individual's needs and presentations and support people to become medically stable.

- The identification of gaps in provision will inform any investment decisions in respect of the mental health investment standard (MHIS) and any wider resources available to deliver improved care.

Objective Four: Helping to support broader social and economic development

- Ensuring that community provision is in place for people with severe and relapsing mental illness will alleviate pressure on other parts of the health system and the wider public sector.

- The health and wellbeing of our workforce, our ability to retain, develop and grow, will contribute to wider social and economic sustainability.

- Actions focus on a service user group who have been traditionally excluded from social and economic opportunities, helping to curate more inclusive and resilient societies.

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

7.1 Improving the care and treatment of individuals who require an intensive and assertive approach from health services is a priority for the NHS. It is directly linked to both population health objectives, using an assertive approach will support preventative health measures and enhance the priority to increase access to community mental health services.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety

QS1 Supporting People to live healthier lives
By providing intensive and assertive step up/ down support as needed will allow people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support.

QS3 Safe and effective staffing
There needs to be enough qualified, skilled and experienced people, who receive effective support, supervision and development working together effectively to provide safe care that meets people's individual needs.

QS4 Equity in access
An intensive and assertive community approach will ensure that everyone can access the care, support and treatment they need when they need it.

QS5 Equity in experience and outcomes
By involving those with lived experience we will actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We can tailor the care, support and treatment in response to this.

QS6 Safeguarding
People with these needs can be very vulnerable to harm from themselves and from others; for a very small number of people relapse can also bring a risk of harm to others. Integrated Care Boards have a duty to provide care and treatment in a way that meets the needs of this group.

Theme Two: Integration

QS7 Safe systems, pathways and transitions
Partner organisations need to be able to refer or escalate cases for this high-risk group of individuals and safety needs to be managed, monitored and assured.

QS8 Care provision, integration and continuity
Care needs to be coordinated and responsive for this cohort of individuals to ensure continuity of care when people move between different services. The use of a step up-step down, multi-agency and multi-disciplinary approach will support integration and continuity

QS9 How staff, teams and services work together
All relevant staff, teams and services are involved in assessing, planning and delivering people's care and treatment and staff work collaboratively to understand and meet people's needs.
Theme Three: Leadership

QS13 Governance, management and sustainability
ICBs need to be assured that the services in their area are able to identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow-up.

QS14 Partnerships and communities
Steering groups understand the duty to collaborate and work in partnership, so that services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

QS15 Learning, improvement and innovation
Steering groups focus on continuous learning, innovation and improvement across organisations and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

9. Risks

9.1 The review of local service provision has highlighted a number of gaps which will need to be addressed. These relate to the following ICB principal risks:

P1 – the ICB is unable to progress meeting its statutory duties to address health inequalities. This risk will be mitigated via immediate short-term actions and further prioritisation of longer-term actions.

P4 - Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience. As

outlined in national guidance, the review has been used as an opportunity to reflect on the community provision in place for people with severe and relapsing mental illness, and in particular the specific actions services need to take to ensure people are receiving and engaging in the care they need. Safety is a pivotal consideration. Progress against identified actions will help mitigate this risk.

P9 - Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives. There is a limited pipeline for certain MH professions and a need, therefore, to think innovatively about career routes and workforce development. Collaborative work is being undertaken to develop a MH workforce strategy to mitigate this risk.

10. Finance

10.1 The action plan in Aopendix One includes short-term actions with no, or minimal resource implications, as well as potential longer-term actions, which may have resource implications. Approval to progress longer-term actions will be sought via appropriate governance structures as transformation work continues.

10.2 NHS England has requested an initial estimate of the direct cost implications of addressing identified gaps in provision. This estimate is to build understanding of the total scale of funding required nationally. A consistent North West approach has been adopted to calculate this estimate, based on NHS benchmarking data for community MH services. To date there has been no further national commitment for funding to address the gaps in service provision.

10.3 Using weighted population for working age adults in Cheshire and Merseyside, it is estimated that an additional 98 WTE staff will be required, at a cost of £6.8m, to address gaps in provision. However, no commitment to funding is currently being sought.

10.4 More detailed work will be required to better understand the skills, competencies and training requirements for both existing and additional staff. Consideration will also be given to any additional digital and estates requirements to provide out-of-hours services to meet the needs of this cohort.

11. Communication and Engagement

11.1 The review included an evaluation of policies and standard operating procedures and obtaining initial feedback from external services and Voluntary, Charity, Faith and Social Enterprise (VCFSE) partners via a short questionnaire.

11.2 Further engagement is planned with a range of stakeholders, including people with lived experience and their carers.

11.3 The National NHS England team will collate national trends from the reviews, use it to inform future policy, as well as communicate the outcomes to the Care Quality Commission and Department of Health and Social Care.

12. Equality, Diversity and Inclusion

12.1 People within this cohort may be socially excluded and typically experience multiple overlapping risk factors for poor health, such as violence and complex trauma. It is important to ensure that opportunities are not missed for preventative interventions to improve health outcomes, reduce inequalities and reduce cost in other services.

13. Climate Change / Sustainability

13.1 Supporting people within this cohort to live healthier more active lives will facilitate delivery of the ambitions of the Cheshire and Merseyside Marmot Community Programme.

14. Next Steps and Responsible Person to take forward

14.1 Following approval by NHS Cheshire and Merseyside Board, delivery of actions will be progressed by the NHS mental health providers and relevant stakeholders. A panel will be convened, chaired by the Strategic Commissioning Lead for mental health and learning disabilities, to ensure that NHS Cheshire and Merseyside meet the 3rd September self-assessment deadline set by NHS England.

15. Officer contact details for more information

- Claire James, MH Programme Director, Cheshire and Merseyside Mental Health Programme
- Clair Haydon, Clinical Director for Mental Health Complex Care for North West England

16. Appendices

Appendix One: Cheshire and Merseyside AIOT Action plan

Appendix One: Cheshire and Merseyside AIOT Action plan

Key:

Complete
On track
Started and on track
Started and not on track

Overarching action	Milestones	Progress RAG rating	
		CWP	Mersey Care
Policies have been reviewed to ensure that patient family and carers are involved, particularly at times of non-engagement	Trusts will review and align policies and procedures to include Intensive and Assertive Outreach standards.	G	G
	Trusts will develop and agree escalation pathways for local services and VCFSE to ensure that quick and easy access to the CMHT is available and communicated.	A	A
	Trusts will ratify policies and procedures to include I&OA standards	G	G
Eliminate 'blanket' policies and practices of using DNA as a reason for discharge	Trusts to review and amend their policies and practices to ensure DNA is never a reason for discharge for this group.	G	G
	Trusts will ensure that discharge as a result of DNA for this group is treated as a never event and reported through this route as per Trust Governance structures	A	A
	Trusts will ratify policies and procedures to ensure that DNA is never a reason for discharge for this group	G	G
	Trusts to escalate any areas of concern that require system support.	A	A
	Trusts to review and identify gaps in EPR systems to identify this group, link to incidents, compliments, comments and complaints quality metrics, and ensure robust governance processes in place.	A	G
	All CMH Team Managers will provide a list of service users who are known within their teams to meet the IO/AO criteria and/ or those who are known to be high risk if they disconnect with services, these will include all those on CTO's	G	G
	All service users identified through the process above will be reviewed by the MDT with the service user and their supports. They will agree a risk management plan and plan of care that takes into account an relapse indicators.	A	G
	This will be shared with all relevant parties including the GP and will detail escalation processes.	A	A
	An internal 'flag' will be agreed within System One so that this cohort can be easily recognised within the EPR system prior to further scoping of a more automated process, possibly within MAST.	A	A

Overarching action	Milestones	Progress RAG rating	
		CWP	Mersey Care
All service users are assessed to see if they are eligible for intensive and assertive community treatment	Develop a Standard Operating Procedure (SOP) to support the identification and the eligibility	G	G
	Any new service users who meet the eligibility criteria will be supported as per the SOP and this will be evidenced within the EPR	G	G
Ensure all service users in this group have an assigned, and appropriately experienced and competent key worker (or care coordinator)	Trust to work across C&M to agree implementation of these standards and what is possible without resource.	G	G
Discharge plans should include early warning signs of relapse and subsequent actions. These plans are shared with the patient, the family, detailed on the patient record, and shared with other agencies.	Trust to review relapse/risk documentation to ensure this ask is met.	G	G
	Trust to review the skills and competency in the workforce to be able to complete this ask and escalate any training needs.	B	G
Rapid re-referral/easy access is possible in the case a service user is discharged but requires additional support due to increasing needs.	Trusts to review/revise processes for re-referral for this group.	G	G
	Trusts to share processes for escalation and rapid referral with wider health and social care teams and VCFSE, housing and support providers.	A	A
Key workers (or care coordinators) stay in contact with the service user (and their inpatient care team) during inpatient admissions	Trusts to review current processes, identify any gaps and formulate plans to address, including system support.	B	B
Assessments and care plans are coproduced with the service user and their family or carers	Trusts to review current processes, identify any gaps and formulate plans to address, including system support.	G	A
Daily planning meetings and weekly MDTs for all service users requiring intensive treatment	Trusts to review current processes, identify any gaps and formulate plans to address, including system support.	B	G
Personalised risk management procedures are in place.	Trusts to review current processes, identify any gaps and formulate plans to address, including system support.	B	G

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

Developing a Framework for Neighbourhood Health Services in Cheshire and Merseyside

Agenda Item No: ICB/07/25/16

Responsible Directors: Clare Watson
Assistant Chief Executive
Alison Lee
ICB Place Director for Knowsley

Developing a Framework for Neighbourhood Health Services in Cheshire and Merseyside

1. Purpose of the Report

1.1 The purpose of the paper is to provide Board members with an update regarding Neighbourhood Health (NH). The paper will describe the development of the Cheshire and Merseyside NH Framework that will support and enable all nine places to build upon and enhance established NH activity.

1.2 It is proposed that an associated formal programme of work for NH aligned to the Framework will encourage wider collaboration and learning and collectively seek to resolve some of the system wide challenges that may impact successful delivery of the six core components of Neighbourhood Health and longer-term outcomes in Cheshire and Merseyside.

1.3 The Framework and Programme resource will also support Cheshire and Merseyside to assure NHSE and wider system partners of progress towards meeting the NHSE neighbourhood health guidance and the strategic ambitions for Neighbourhood Health outlined in the Government's recently published NHS 10-year Plan.

2. Executive Summary

2.1 This report provides an overview of the proposed Cheshire and Merseyside Neighbourhood Health Framework**.** It includes:

- National and regional policy context for Neighbourhood Health ambitions and expectations
- Information resulting from Neighbourhood Health Maturity Assessments completed by Place based teams in April 2025
- An outline of the Framework, vision and driver diagram for Neighbourhood Health in Appendix One to this paper
- Information about the National Neighbourhood Health Implementation Programme
- Cheshire and Merseyside Neighbourhood Health Principles and Next Steps.

3. Ask of the Board and Recommendations

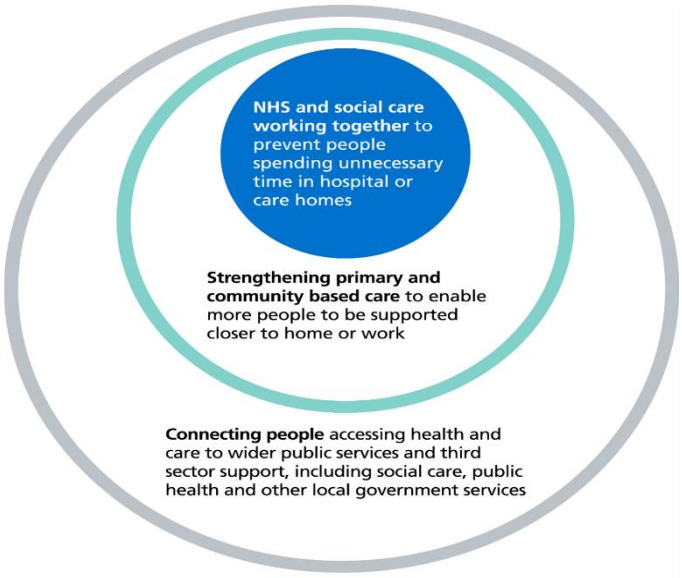
3.1 **The Board is asked to:**

- **note** the work being undertaken both centrally and at Place level by the ICB and other system partners to support the delivery of Cheshire and Merseyside NH development.
- **Approve** the Neighbourhood Health Framework and principles as described within this report.
- **agree** the next steps for this key priority activity for the ICB and for wider system partners.

4. Background

4.1 In January 2025, NHSE published its new NH guidelines for ICBs, Local Authorities health and care providers and wider partners such as the VCFSE sector. NHSE describe these guidelines as 'short and permissive' to allow systems to develop a framework for action that is governed locally and 'tailored to local needs'.

4.2 The appendix to the guidelines also provided specific detail around six components of neighbourhood health activity that NHSE considered must be at the core of planning and progress for ICBs in 2025/26 and beyond. The diagram below shows the aims for all neighborhoods over the next five to ten years.



4.3 Cheshire and Merseyside can already demonstrate good examples of collaborative working to develop NH models that align to the components of the new NHSE guidance. These six component areas are:

- Population Health Management
- Modern General Practice
- Standardising Community Health Services
- Neighbourhood Multi Disciplinary Teams
- Integrated Intermediate Care (Home First Approach)
- Urgent Neighbourhood Services.

4.4 In 2025/26 ICBs and their system partners have been asked to make progress in these six areas by:

- **standardising the six core components of existing practice** to achieve greater consistency of approach
- **bringing together the different components into an integrated service offer** to improve coordination and quality of care, with a focus on people with the most complex needs
- **scaling up** to enable more widespread adoption
- **rigorously evaluate** the impact of these actions, ways of working and enablers both in terms of outcomes for local people and effective use of public money.

5. Neighbourhood Maturity Assessments

5.1 Cheshire and Merseyside's nine Places are at differing stages of maturity in developing NH models. Places were asked to complete a local maturity assessment to describe their baseline activity and NH progress up to April 2025. They self-assessed against the six core NH component areas described above. They were also asked to share their overall approach for their NH Place Leadership and governance, IT issues and finances. Information was also collated regarding their proposed NH defined areas and Population sizes.

5.2 Due to the size and complexity of the returns the individual assessments were run through AI software which then was able to aggregate and analyse the information. It could then be streamlined and collated in a way that would clearly describe:

- a summary of each Core Component NH area by individual place.
- the document also highlighted where there are gaps and infrastructure challenges and provided some useful intelligence to enable the ICB and partners to develop a consistent approach across Cheshire and Merseyside and identify examples of existing good practice.

Maturity Assessment Summary (Aggregated Position)

5.3 The summary document tells us that all nine Places have taken a **Place-led approach,** and many have aligned with Primary Care Networks (PCNs) or with local authority geographies. This has already been achieved in Cheshire East, Cheshire West, Sefton, and Liverpool. Knowsley, Wirral, St Helens, Halton and Warrington have recently resolved their approach and shared their proposed NH areas.

5.4 Every Place is establishing a robust **governance structure**—ranging from formal Place Partnership Boards to NH strategic task groups—to oversee the development and implementation of neighbourhood working. Most are supported by joint leadership arrangements between NHS organisations, local authorities and wider system partners.

5.5 **Clinical and professional leadership** is embedded to varying degrees. Some areas have dedicated clinical leads at neighbourhood level (e.g. Sefton, Knowsley, Liverpool), while others are still formalising this approach. All Places acknowledge the importance of community and carer engagement, though actual approach and activity is currently inconsistently completed.

5.6 **Digital integration, information sharing, and data use** are evolving and there is some variance across Place. The CIPHA platform and Data into Action Programme is well established and supporting Population Health Management at place (e.g. Cheshire East and West, Liverpool, Sefton) some places also use digital enablers such as Shared Care Records and electronic programme management tools, while others have (e.g. Halton, Wirral) identified this as an area requiring significant improvement.

5.7 The assessments also identify that despite progress, there are some challenges at both Place and system levels which are outlined below:

- **Inconsistent Engagement**: Most Places acknowledge that direct involvement of people, carers, and those with lived experience is limited or underdeveloped. Healthwatch is often used but this doesn't fully substitute for co-production with communities.
- **Boundary alignment**: there are several places where PCN footprints do not align with local authority structures. This may potentially complicate emerging NH service delivery.
- **Data and IT Systems**: There are variances across places who highlight issues with data sharing and digital interoperability between health, social care and other partners. Some Places have implemented effective digital tools, whilst others report systemic challenges. A Cheshire and Merseyside wide shared care record is still not fully developed.
- **Workforce Development**: Workforce planning linked directly to neighbourhood health transformation is underdeveloped in many Places. Cheshire East has experienced delays due to OD capacity, and Halton is in the early stages of initiating work in this area.
- **Funding Mechanisms**: While many Places use the Better Care Fund (BCF), not all have pooled budgets or formalised joint investment strategies.

6. Neighbourhood Health agreed geographical areas at place

6.1 The table below shows the current position (as of June 2025) of the proposed Neighbourhood Health areas across Cheshire and Merseyside. All nine places have now identified their proposed NH areas. In total there 59 areas across the nine places. Most Neighbourhood Health areas are within a range of 30-50k population but there are some larger ones which have developed due to service issues or geographical or boundary reasons. Some areas, such as Cheshire East / West and Liverpool, have well established Neighbourhood Health areas but others, such as Warrington and Wirral, have a complex system and are working though their Neighbourhood Health development in with partners.

Place	Number of Neighbourhood Areas	PCNs	Number of LA Localities
Cheshire East	8	9	8
Cheshire West	9	9	4
Halton	2	2	4
Knowsley	4	3	4
Liverpool	13	9	13
Sefton	8	2	3
St Helens	4	4	7
Warrington	5	5	4
Wirral	6	6	9
Total	**59**	**49**	**56**

6.2 As stated, there is still some work required in some places to refine and formalise

individual proposed NH areas through Place governance processes, but it is hoped that this will be completed by the summer of 2025. All places are working towards being able to describe in more detail the proposed population size, geographical outline and service outline of all their NH areas. NB Having clear geographical boundaries will be one of the essential criteria to be a pilot area of the national programme (see section 10 below)

7. Fit for the Future- 10 Year Health Plan for England

7.1 The recently published NHS 10 Year Health Plan for England reinforced the size of the ambition and expectation for the shift towards Neighbourhood Health. A summary of some of the key points and ambition for the shift t0 Neighbourhood Health are outlined below:

- **Neighbourhood Health Centres-** establish an NHC in every community, beginning with places where healthy life expectancy is lowest - a 'one stop shop' for patient care and the place from which multidisciplinary teams operate. NHCs will be open at least 12 hours a day and 6 days a week-40/50 in first year
- **Comprehensive community hubs** delivering GP, nursing, pharmacy, mental health, and allied health services.
- **Shift in capital investment** towards community centres and exploring private finance mechanisms in some cases
- **Launch of a new NHS workforce plan-**aligned to NH, increased GP numbers and broader recruitment and training of allied health professionals
- **Digital enablement for Neighbourhood Health-**transform the NHS app, including self-referrals, AI advice and guidance and digital patient access, empowerment, and care planning. By 2028, the app will be a full front door to the entire NHS
- **Single Digital Patient Record** - to enable more co-ordinated, personalised, and predictive care
- **Prevention and Public Health in the Community-**Embed prevention services in neighbourhood hubs: weight-loss support, smoking cessation, alcohol counselling
- **Enforce public health measures**: obesity interventions, food advertising restrictions, sugary/fizzy drinks rules
- **Expand mental health**, genomics, and chronic disease prevention in the community setting
- **One-stop-shop hubs** offering healthcare and lifestyle support
- **Individuals to be cared for at home wherever possible**, reducing hospital reliance

8. Cheshire and Merseyside Neighbourhood Health Framework

8.1 A draft Cheshire and Merseyside Neighbourhood Health Framework has been developed with contributions from Place-based partnerships (involving Local Authorities, the VSFCE sector, GPs, Trusts and other partners). It was shared widely with system partners at a workshop in May 2025 and sent to all ICB Board Partners for comment. Partners who attended the workshop were asked to share the framework with their wider organisation/sectors and to share feedback before a second workshop held earlier this month (July 2025). The framework describes a blueprint that would:

- **Establish a clear and shared vision for the Neighbourhood Health Service,** so that we can communicate clearly what it means for professionals, patients and service users, and our communities across Cheshire and Merseyside.
- **Promote consistency, whilst recognising the different levels of maturity that exist across nine places**, building from where we are, minimising disruption and being flexible and responsive to local needs.
- **Be clear on what success means for Cheshire and Merseyside** and the role of systems, providers, places, and neighbourhoods in delivering this for neighbourhood health.
- **Sets out the roadmap for the next year** and begins to create our long-term system Neighbourhood Health delivery plan through ongoing communication and debate with our partners.

8.2 The framework will be presented during the Board meeting and is attached as Appendix One

9. National Neighbourhood Health Implementation Programme

9.1 NHSE launched the National Neighbourhood Health Implementation Programme on the 10 July 2025 and the closing date is the 8th of August 2025. There is an open invitation for Places to join the first wave of the Programme and it is envisaged that forty-two places (not ICBs) will be asked to participate in the first wave.

9.2 The application process has been shared with senior leaders across the ICS and information about the programme is available on the NHS England website.

9.3 A summary of the application process is as follows:

- Places to provide background information including leadership at Neighbourhood level
- Assurance of CEO support from the ICB and Local Authority and support from the Mayoral combined authority
- Information regarding Place resources that will be assigned to the Programme
- Anticipated achievements if included in the programme
- How places can contribute to the shared learning with other participants
- How outcomes will be improved for the 20% most deprived population.

9.4 The first phase will begin in 2025 and will see Places and ICBs receive access to a range of support including a national coach, national and regional networks to support peer learning and evidence, best practice and tools and materials which support the development of Neighbourhood Health.

9.5 Links to the information and application process of the National Neighbourhood Implementation Programme are appended to this report.

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

Objective One: Tackling Health Inequalities in access, outcomes and experience
The development of the Neighbourhood Health Framework for Delivery is a key ambition in supporting the three shifts in the new NHS 10 Year Plan-Fit for the Future. It will support care closer to home and improve and move to integrate services across health, social care and VCSFE sector. It also will also seek to improve resident and patient experience and access to services locally.

Objective Two: Improving Population Health and Healthcare
The development and targeted application of PHM tools will be a key enabler in the development of the Neighbourhood Health Framework.

Objective Three: Enhancing Productivity and Value for Money
Over time the Neighbourhood health Framework will support the shift to Neighbourhood Health services and enhancing productivity and Value for money with innovative commissioning of services and contractual changes.

Objective Four: Helping to support broader social and economic development
The Neighbourhood Health Framework will be working with system wide partners and on the two Devolution footprints to ensure that wider social and economic development are considered in the shift towards increasing Neighbourhood Health services.

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

11.1 The shift from a National Health Service to a Neighbourhood Health Service is outlined in the objectives in the Annual Delivery Plan.

12. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety
Improving the quality, experience and safety of services for residents will play a key part in the development of the Neighbourhood Health Framework.

Theme Two: Integration
Working towards integrated service provision across health and wider sector partners is a key ambition of the Neighbourhood Health Framework.

Theme Three: Leadership
To deliver the ambition of the Neighbourhood Health Framework it will be necessary to look at a new style of leadership with an emphasis on **community involvement** in leadership structures at Place level.

13. Risks

13.1 Once the Framework is approved a formal Programme will be developed for Neighbourhood Health which will include a risk log.

14. Finance

14.1 There are no financial implications at present but as places start to develop and implement changes to commissioning, contracts and service provision more financial and contractual input will be required.

15. Communication and Engagement

15.1 Once the Framework is approved a formal Programme will be developed for Neighbourhood Health which will include a Comms Plan and regular stakeholder events.

16. Equality, Diversity and Inclusion

16.1 Equality, Inclusivity and improving health equity are integral in our approach to the development of Neighbourhood Health across the nine places of Cheshire and Merseyside.

17. Climate Change/ Sustainability

17.1 The Neighbourhood Health Framework will ensure that the long-term sustainability of and easy access of any estate/ building is included in any plans and changes to local service provision.

18. Officer contact details for more information

Clare Watson
Assistant Chief Executive

Alison Lee
Place Director for Knowsley

19. Appendices

Appendix One: Neighbourhood Health in Cheshire and Merseyside - A Framework for Delivery

Appendix Two National Neighbourhood Health Implementation Programme
www.england.nhs.uk/long-read/your-invitation-to-be-involved-in-the-national-neighbourhood-health-implementation-programme/

NHS
Cheshire and Merseyside

Neighbourhood Health in Cheshire and Merseyside- A Framework for Delivery

Presentation to the ICB Board

25 July 2025

What is covered in the Framework:

NHS Cheshire and Merseyside

Aim: To set out a blueprint for Neighbourhood Health- the elements we want to see in each of our 9 Borough-based partnerships and emerging 59 neighbourhoods

- Vision
- Definitions and Foundations
- Scope (the 3 circles of neighbourhood health)
- Key elements of blueprint
- Key features of integrated neighbourhood teams
- Impact measures for a neighbourhood dashboard
- Roadmap
- Summary of Feedback
- Next steps

Introduction

NHS
Cheshire and Merseyside

Cheshire and Merseyside will respond to the 3 NHS "missions":

- Shift services out of hospital and into the community
- NHS becomes as much a Neighbourhood Health Service as it is a National Health Service.
- A shift from Board to (electoral) ward

Our Framework outlines how all age Neighbourhood Health will be developed across Cheshire and Merseyside. It responds to national guidance and describes how Cheshire Mersey wide enabling actions will support Place led development and ensure that neighbourhood working reflects and models wider policy.

This Framework:

- **Establishes a clear and shared vision for the Neighbourhood Health Service,** so we can communicate clearly what it means for professionals, patients and service users, and communities across Cheshire and Merseyside.
- **Promotes consistency, whilst recognising the different levels of maturity that exist across nine places**, we will build from where we are, minimise disruption and be flexible and responsive to local needs.
- **Is clear on what success means for Cheshire and Merseyside** and the role of systems, providers, places and neighbourhoods in delivering this for neighbourhood health.
- **Sets out our roadmap for the next year** and begin to develop our long-term system delivery plan through ongoing communication and debate with our partners

NHSE Neighbourhood Guidelines 2025-26

NHS Cheshire and Merseyside

The NHSE guidance on neighbourhoods emphasises that we need to move to a neighbourhood health service that will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery.

It has set out 6 initial core components of a neighbourhood approach

1. Population Health Management
2. Modern General Practice
3. Standardising Community Health Services
4. Neighbourhood Multi-Disciplinary Teams
5. Integrated intermediate care with a 'Home First' approach
6. Urgent neighbourhood services

Guidance has indicated that the focus in 2025/26 should be supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations. In Cheshire and Merseyside for 25/26 this will be our proposed initial scope

The Ten-Year Health Plan- Outlining the key ambitions for Neighbourhood Health

NHS Cheshire and Merseyside

- **Neighbourhood Health Centres-** establish a NHC in every community, beginning with places where healthy life expectancy is lowest - a ‘one stop shop’ for patient care and the place from which multidisciplinary teams operate. NHCs will be open at least 12 hours a day and 6 days a week-40/50 of them in first year
- **Comprehensive community hubs** delivering GP, nursing, pharmacy, mental health, and allied health services.
- **Shift in capital investment** towards community centres and exploring private finance mechanisms in some cases
- **Launch of a new NHS workforce plan-**aligned to NH, increased GP numbers and broader recruitment and training of allied health professionals
- **Digital enablement for Neighbourhood Health-**transform the NHS app, including self-referrals, AI advice and guidance and digital patient access, empowerment and care planning. By 2028, the app will be a full front door to the entire NHS
- **Single Digital Patient Record** - to enable more co-ordinated, personalised and predictive care
- **Prevention and Public Health in the Community-**Embed prevention services in neighbourhood hubs: weight-loss support, smoking cessation, alcohol counselling
- **Strong public health measures**: obesity interventions, food advertising restrictions, sugary/fizzy drinks rules
- **Expand mental health**, genomics, and chronic disease prevention in the community setting
- **One-stop-shop hubs** offering healthcare and lifestyle support
- **Individuals to be cared for at home wherever possible**, reducing hospital reliance

Vision: Neighbourhood Health in Cheshire and Merseyside

NHS
Cheshire and Merseyside

Make healthcare better by bringing it closer to where people live.

Health and care providers working together to help people before they get really sick and make it easier for everyone to get care

Integrated neighbourhood health teams will work with local people and other organisations so everyone can be healthier and have the same chance to stay well

What we mean by neighbourhood working (adapted from Liverpool)

Neighbourhoods

A specific geographical area or community that resonates with residents, that local services, organisations and communities can coalesce around to address needs and improve outcomes. This is broader than integrated neighbourhood teas and includes ongoing partnerships with community groups, residents, and local stakeholders to address a wide range of community issues, including community development and systemic improvements.

Multi-disciplinary working

Representatives from different disciplines coming together to share expertise, coordinate care, and contribute their specific skills to address the needs of an individual/family or group. Collaboration tends to occur at key points, such as MDT meetings, reviews, or case discussions and individuals typically maintain separate roles, responsibilities and different back-office functions.

Integrated Neighbourhood Teams

Developing Integrated Neighbourhood Teams will be part of how we deliver care at a neighbourhood level more broadly. INTs go beyond multi-disciplinary working by fully integrating representatives from health (primary, community, acute and specialist) social care, and the voluntary sector into a single, place-based team to deliver seamless, coordinated care within a defined area..

Basic Ingredients

NHS
Cheshire and Merseyside

- ***Neighbourhood working is based on a different relationship between public services and residents.***

- Our initial focus: establishment of multi-agency integrated neighbourhood teams working on geographical footprints of 30-50k population where front-line public service staff know each other, can work collaboratively, and can build on the strengths and assets of residents.

- Multi-agency working addressing identified cohorts of the population to reduce, delay, or eliminate risk of escalated harm, poor outcomes, and unnecessary use of costly, reactive public service spend.

- Integrated neighbourhood teams (INTs) to include primary care, community care, adult and children's care, mental health services, and aspects of secondary care delivered in neighbourhoods. **These teams should ideally include social workers and social care providers .**

NHS
Cheshire and Merseyside

Wider scope – as we mature

- The guidance sets an ambition for systems to move to a broader approach to neighbourhood health:
- focusing on population groups with less complex needs to enable more people to be supported in their homes and community settings
- connect people to wider public services and third-sector support that can improve health and wellbeing.
- Recognition that **health is shaped by social conditions**—not just clinical care.
- Importance of **long-term, preventative collaboration** across NHS, voluntary sector, and public agencies.

The 3 circles of neighbourhood ‘health’
(Kings Fund)

NHS
Cheshire and Merseyside

1. The NHS Version

- Focuses on improving community-based health and social care.
- Aims to provide better coordinated and more responsive services.
- Targets high-resource users or those at risk of frequent service use.
- Emphasises prevention and proactive support to reduce hospitalisation.
- Common intervention: **integrated neighbourhood teams** (30,000–50,000 population), as recommended in the **Fuller stocktake**.
- Teams include a range of health and social care professionals.
- Forms part of NHS England’s neighbourhood health guidance.
- This is where we are starting in 25/26

Neighbourhood Health-Local Government

Cheshire and Merseyside

2. Local Government Version

- Also based on **multi-agency collaboration**, but broader in scope.
- Includes representatives from:
  - Children, families, and young people services
  - Adult social care
  - Housing, employment, welfare services
  - Police, antisocial behaviour teams
  - Voluntary sector and community health professionals

- Focus: support for individuals/families facing poverty, deprivation, and social exclusion.
- Addresses complex, multi-faceted needs—not always health as the main issue.

Neighbourhood Health-Community Led

NHS Cheshire and Merseyside

3. Community-Led Version

- Focuses on **community empowerment and local action**.
- Emphasis on working **with** communities rather than doing **to** them.
- Aims to build community leadership and leverage local assets and relationships.
- Hyper-local focus: often just a few streets, not tens of thousands of residents.
- Professionals act as **facilitators**, not primary drivers.
- The need for **resident, patient, and service user feedback** to be central to outcome measures.
- Emphasis on **community involvement** in leadership structures at Place level.
- Importance of **systematic and meaningful engagement** with the whole population (30–50k).
- A call to **shift power from institutions to communities**.
- Framing communities as **active agents of health**, not passive recipients.

The Model Neighbourhood – Driver Diagram

NHS Cheshire and Merseyside

Principles

Neighbourhood delivered place-led, Cheshire Mersey enabled

Builds on strengths of people and communities

Acts on the social determinants of health and gets to the root cause of problems

Names, not numbers (residents/patients and colleagues)

Scope

All-age services:

Start with 25/26:

All NHS primary and community services – including community mental health

Aim for:

All public health services

Adult Social Care

Community Services

VCFSE Services

Social Prescribing

Full delivery:

Public Services – Housing; DWP Employment Support; Police, Fire, Probation Services; Schools

Key Features

Start with:

30-50k population

Integrated leadership and accountability in Place and neighbourhood

Aim for:

Services aligned to neighbourhood geographies

Co-located integrated neighbourhood teams

Pooled public service budgets and shared outcomes frameworks

Budgets reprofiled to prevention and proactive care

Enablers

Local Leadership through Place-based partnership boards and identified lead provider organisation

Digital – NHS app as well as local and national innovation

Population Health Management system (CIPHA)

One workforce approach

One Public Sector Estate and better use of NHS Estates

Shared leadership development

Impact

Examples:

Start with 25/26

Reduced utilisation of acute, residential and crisis-based services:

- A&E Attendances

-Non-Elective Hospital Admissions

-Admissions to Residential Care

-Out of Area Placements

From 2026 onwards- Aim for reduction in:

-Pupil Referral Units

-Police Call Outs

-Households in Temporary Accommodation

Improvements in key public service measures:

-School readiness;

-Self-reported well-being

Integrated Neighbourhood Teams – key features

NHS Cheshire and Merseyside

Use data/intelligence such as CIPHA to help with early identification and prevention

Each team will serve a local area with about 30,000 to 50,000 residents.

They will include essential services like GPs, Mental Health, Community Nursing and Therapies, Children's Services (including pre- and post-natal care), Health Visiting, Social Prescribing, Community Pharmacy

They will also have a dedicated lead organisation at Place level e.g. GP practices, community providers, or local council

Staff will follow a "no wrong front door" policy—people can access support digitally, by phone, or in person, and will be directed to the right service.

Wherever possible, services will be based in shared locations (or hubs) with a single reception.

There will be transparency of resources within each INT, coordinated by the Place-based Partnership . Places will work with the provider collaborative as they develop the core community service offer

INTs will connect flexibly to services that work at a borough or regional level.

They will also be able to access specialist services through hospitals and other specialist providers as needed.

Clear use of digital tools to engage patients, connect community assets and drive efficiency for staff

Need for broader integration of all providers: pharmacy, dentistry and optometry and inclusion of secondary care (hospital providers)

Recognition of differences in how people access and interact with different care providers

Impact measures

NHS Cheshire and Merseyside

NHSE has set out some key metrics to measure the impact of neighbourhood health. As a Cheshire and Merseyside system, we will need to consider how we evolve and translate these national metric into outcome focused neighbourhood dashboards

- Avoiding or slowing health deterioration, preventing complications and the onset of additional conditions, and maximising recovery whenever possible to increase healthy years of life
- Streamlining access to the right care at the right time, including continued focus on access to general practice and more responsive and accessible follow-up care enabled through remote monitoring and digital support for patient-initiated follow-up
- Maximising the use of community services so that better care is provided close to or in people's own homes reducing emergency department attendances and hospital admissions, and where a hospital stay is needed, reducing the amount of time spent away from home and the likelihood of being readmitted to hospital
- Reducing avoidable long-term admissions to residential or nursing care homes
- Reducing health inequalities, supporting equity of access and consistency of service provision
- Improving people's experience of care, including through increased agency to manage and improve their own health and wellbeing
- Improving staff experience
- Connecting communities and making optimal use of wider public services including those provided by the VCFSE sector
- Desire for **community-relevant outcome metrics**, not just clinical indicators.
- Need for **storytelling and qualitative insights** alongside quantitative data.

Logic Model - DRAFT

NHS Cheshire and Merseyside

Input	Activities	Outputs	Short Term Outcomes	Medium Term Outcomes	Long term Outcomes
Data to identify need Population Health Management Tools and identified patient cohorts Coproduction with communities Integrated workforce Integrated digital record Understanding of the evidence base for interventions Focus on social determinants of health Shared public sector estate	Population Health Management approach Identification of priority cohorts Conversations with communities, community leaders and wider system partners Multidisciplinary integrated teams Person-centred care plans Evidence based preventative interventions Social prescribing interventions Evidence based medical interventions	**Primordial prevention** Number of people receiving housing support Number of homes receiving retrofitting for energy efficiency Amount of energy vouchers secured and distributed Number of people accessing employment support Number of families accessing benefits related entitlements **Primary prevention** Number of people accessing smoking cessation services Number of people accessing weight management services Number of people participating in physical activity programmes Number of people receiving routine vaccinations Increase in the number of people being proactively identified for targeted support **Secondary prevention** Number of people being proactively identified for targeted support Number of eligible people participating in the national screening programmes Number of high intensity user care plans Number of drug and alcohol service referrals Number of mental health service referrals **Tertiary Prevention** Number of frailty care plans Number of falls assessments and referrals for patients with a medium and high frailty score Number of medication reviews Number of people accessing disease rehab programmes	**Primordial prevention** Reduced risk of eviction or homelessness Reduced energy bills Sustained employment for 6-12 months Increased benefits related income **Primary Prevention** Reduced smoking prevalence Reduced obesity prevalence Increased physical activity levels Increased vaccination rates Reduced risk of communicable disease **Secondary prevention** Increased screening programme rates Reduce ambulance usage Improving access to GPs appointments Reduced A&E attendances Reduced disease specific emergency hospital admissions Increased uptake of drug and alcohol services Increased uptake of mental health services **Tertiary prevention** Reduced frailty scores Improved medication adherence Reduced disease specific emergency hospital admissions	**Primordial prevention** Improved school attendance Secure housing for 6-12 months Increased household income Increased rates of secure employment **Primary prevention** Reduced prevalence of CVD Reduced prevalence of respiratory disease Reduced prevalence of preventable cancers Reduced prevalence of diabetes Reduced prevalence of vaccine preventable diseases Increase in the percentage of cancers diagnosed at stage 1 and 2 **Secondary prevention** Increase in the percentage of patients who describe their experience of their GP as good Reduced waiting times for diagnostic procedures Reduced readmission rates Reduction in drug and alcohol use Sustained abstinence from drugs and alcohol **Tertiary prevention** Reduced disease complications Increased Quality of Life Scores Increased wellbeing scores Reduced falls related emergency admissions Reduced polypharmacy Reduced social care admissions	**Primordial prevention** Improved educational attainment Reduction in homelessness Reduced fuel poverty rates Improved energy efficiency of C&M Housing Stock Reduction in unemployment rate Reduced poverty rates Increased life expectancy Reduced gap in life expectancy **Primary Prevention** Increased healthy life expectancy Reduced gap in healthy life expectancy Herd Immunity for vaccine preventable diseases Increased 5-year cancer survival rates **Secondary prevention** Reduction in ED waiting times Reduction in ambulance response times Reduction in number of bed days Reduction in mental health bed days **Tertiary prevention** Reduction in medication costs Reduced disease specific mortality

Road map for 2025-26: Place Led, Cheshire Mersey enabled.

NHS Cheshire and Merseyside

Confirm Foundations in Place

- Confirmed neighbourhood footprints at c30 to 50k population covering whole locality
- All local partners align health and care service delivery to neighbourhoods
- INTs in all neighbourhoods
- Clear arrangements in place for working with partners in neighbourhoods – including all local authority services, VCFSE and Housing providers

By End of June 2025

Confirm Approach for NHSE Neighbourhood Components

- Population Health Management
- Modern General Practice
- Standardising Community Health Services
- Neighbourhood Multi-Disciplinary Teams
- Integrated intermediate care with a 'Home First' approach
- Urgent neighbourhood services

NHSE Neighbourhoods Guidance 2025-26

Plus confirmation of neighbourhood implementation of national model for MDTs for Children and Young People –

By End of June 2025

Implement Population Health Management Approach

- PHM established and embedded: understanding of neighbourhoods through data and community connections driving preventative approach
- Processes in place for risk stratification. In 2025/26, the focus should be on adults, children and young people with complex health and social care needs who require support from multiple services and organisations (NHSE 2025/26 guidance)
- Dashboards established covering all aspects of neighbourhood delivery (to be developed with leaders at Place level and building on existing dashboards e

By end of 2025/26

Confirm Road Map to reach Optimal Model

- Optimal model to be co-designed with Cheshire Mersey system, Places and other partners – first workshop 22/5/25
- Places develop roadmap to deliver optimal model (by end Q2 202526)

Road Map in Place by end of Q2 i2025/26

National Neighbourhood Health Implementation Programme

NHS Cheshire and Merseyside

- Launch of a National Implementation programme. An open invitation for places to join the first wave of the Programme. Will be 42 Places chosen across England.
- Aims to support Places that are already making progress but who may be impeded by problems like misaligned incentives and performance management processes that are not aligned with system priorities
- Focus on learning together, sharing solutions, tackling challenges and delivering improvement. Working at scale both within Place and alongside Places across the country simultaneously, accelerating the learning.
- The first phase will begin in 2025 and will see Places and ICBs receive access to a range of support including a national coach, networks to support peer learning and evidence, best practice and tools and materials which support development. The Programme will inform future strategy and policy, including identifying barriers and enablers.
- An experienced national coach will be allocated to assist places on the programme
- Places (through the ICB) to identify a full-time place-based coach for 12 months of the programme, who will be coached in large scale change, and be the Place coach to work alongside the national coach. Places must also have clinical and managerial leads for all their neighbourhood teams.

Next Steps

NHS
Cheshire and Merseyside

- Sign off the framework as presented today
- Deliver the initial focus as per 25/26 guidance
- Build the programme governance and resource that can support and enable the nine places to progress
- Support Places as required with their applications for the National Neighbourhood Health Implementation Programme (closing date is 8th of August 2025)
- Further develop the public health logic model/driver diagram to be clear on outcomes and success measures

Department of Health & Social Care

NHS

Dr Claire Fuller
Co-National Medical Director (Primary Care)
NHS England

Tom Riordan
Second Permanent Secretary
Department of Health and Social Care

ICB Chief Executives
Local Authority Chief Executives

Cc:
NHSE Regional Directors
Regional Medical Directors
Regional Directors of Primary Care and Public Health
NHSE Regional Neighbourhood Health Leads
ICB Heads of Primary Care

9 July 2025

Dear Colleague

Your invitation to be involved in the National Neighbourhood Health Implementation Programme

We are delighted to share an open invitation for you to participate in the National Neighbourhood Health Implementation Programme (NNHIP). We are inviting applications from one of more of the Places in your geography to join the first wave of the programme, with your support.

As explained in the 10 Year Health Plan, Neighbourhood Health is central to the Government's ambition to shift care from hospitals to community, analogue to digital and delivering sustainable health and care services, moving from sickness to prevention. There are many people who experience complex problems in our communities. For example, children from challenged households, people with enduring mental illness, those not working due to disabilities, people with multiple long-term conditions and those experiencing poorer health outcomes compounded by the wider social determinants of health. No single agency working alone can adequately deal with the multiple and often complex issues impacting on the health and wellbeing of the people and communities we serve. Our current ways of working mean resources are not deployed as effectively as possible, creating pressure across the whole health and care system. This places avoidable demand on local authorities, social care, primary care and community care, and A&E and generates unnecessarily high rates of unscheduled admissions and delayed discharges - and most importantly poorer experience of care and outcomes for individuals and communities. A response to these and similar problems requires the coordinated mobilisation of the assets in a community including communities themselves. We need a radical shift in culture, allocation of resources and ways of working. This is at the heart of Neighbourhood Health and what we will begin to construct together. It is mission critical.

We know that many Places are already making progress but often are impeded by problems like misaligned incentives and performance management processes that are not aligned with system priorities. The NNHIP seeks to build on success to date and the new approaches set out in the 10 Year Health Plan - taking a test, learn and grow approach - to transform the health and care of

neighbourhoods. The aim of this new national programme is to accelerate the work you are doing, or planning to do, by learning together, sharing solutions, tackling challenges and delivering improvement, adapting those solutions to your own circumstances. More than that, it will be working at scale both within your Place and alongside Places across the country simultaneously, accelerating the learning.

Our approach

We are conscious of the pressures many people are under, and it is our intent to develop Neighbourhood Health in a facilitative way, incrementally but swiftly.

We will work with Places and their ICBs - who will need the willingness to explore new approaches to commissioning Neighbourhood Health Services and supporting the development of neighbourhood providers and multi-neighbourhood providers. The initial focus for the first Places will be creating Neighbourhood Health systems and processes for adults with multiple long-term conditions and rising risk before progressing to other areas. In addition, we will also work with Places on developing the new ways of working and the system enablers that underpin this. This will build on and not replace work that has already been progressing in many places and therefore, whilst firm on intent and measuring progress, there will be full flexibility to deliver in ways that are shaped locally and make sense to you.

The NNHIP will work with and complement other relevant test and learn programmes.

The NNHIP will be overseen by a joint Task Force between DHSC and NHSE. The small steering group of the task force will contain people from the front line from local authorities, voluntary sector and health organisations who have already delivered some of the changes we want to see. The Chair of the Task Force will be Sir John Oldham, a GP by background who is experienced in introducing quality improvement methods into the NHS and designing and delivering large-scale change programmes.

How to get involved

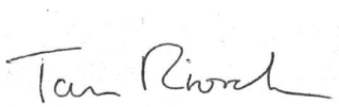
We encourage all those interested to apply. Applications need to be a collaborative and collective process amongst the different provider organisations in a particular geography. We welcome one or more Place applications from systems.

We are very much looking forward to receiving your applications and welcoming successful Places on to the first wave of the NNHIP.

I know you would agree that this is great opportunity for you and your Places, and we believe that individually and collectively, we can make the change we need. We hope you will join us in acting now for the future.

Applications (template attached to this letter) need to be submitted by the **8 August** to the following email address: england.neighbourhoodhealthserviceteam@nhs.net. We are holding a webinar at **15:30-16:30 on Tuesday 15 July** to support applications. Please sign up here if you are interested in attending. Any queries or questions not covered in the attached FAQs can also be sent to england.neighbourhoodhealthserviceteam@nhs.net.

With kind regards



Dr Claire Fuller
Co-National Medical Director (Primary Care)
NHS England

Tom Riordan
Second Permanent Secretary
Department of Health and Social Care

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

Winter Planning 2025/26

Agenda Item No: ICB/07/25/17

Responsible Director: Anthony Middleton
Director of Performance & Planning

Winter Planning 2025/2026

1. Purpose of the Report

1.1 This paper sets out the national expectations for winter planning for 2025/26 as outlined in NHS England's *Urgent and Emergency Care Plan 2025/26*, and provides a high-level summary of the winter planning assurance requirements for Integrated Care Boards (ICBs), Acute Trusts, and Mental Health Trusts, as captured in the national winter assurance template.

2. Executive Summary

- NHS Cheshire and Merseyside's winter plan outlines how the ICB will address NHS England's urgent and emergency care priorities for 2025/26. Key targets include faster ambulance response times, reduced A&E and mental health delays, and improved discharge processes.

- Plans are coordinated through five locality areas, each led by a Senior Responsible Officer, feeding into a system-wide plan due to be submitted July 2025. No extra revenue funding is available, though national capital investment supports urgent care infrastructure.

- The plan addresses system risks and supports strategic objectives around urgent care improvement. Final submissions and NHS stress-testing are scheduled for summer and early autumn 2025.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **note** the national expectations and process on winter planning and the Cheshire & Merseyside approach to fulfilling the winter planning requirements.

4. Background

4.1 National Context and Priorities: The NHS is expected to deliver a significant improvement in urgent and emergency care (UEC) performance during winter 2025/26. The following national priorities and targets have been set for delivery across systems:

Key National Performance Priorities

- **Ambulance Response Times**: Reduce average response for Category 2 calls to <30 minutes.
- **Ambulance Handover**: Meet the 45-minute handover target to release 550,000 ambulance hours.

- **A&E Four-Hour Standard**: Achieve a minimum of 78% of patients admitted, transferred, or discharged within 4 hours.
- **Eliminate Long Waits**: Reduce 12-hour waits to <10% of emergency attendances; end corridor care.
- **Mental Health**: Reduce >24-hour waits for mental health beds; eliminate inappropriate out-of-area placements.
- **Discharge**: Target a reduction in 21+ day delayed discharges (currently ~30,000 patients/year).
- **Children's UEC**: Improve timeliness of care for children in emergency settings.

4.3 **System-Wide Requirements:** Each ICB must ensure submission of a signed-off winter plan by summer 2025. These plans must:

- Expand community-based urgent care (e.g. virtual wards, urgent community response).
- Improve discharge coordination across health and social care.
- Set and monitor local performance targets for discharge pathways.
- Strengthen workforce and vaccination plans (flu, RSV).
- Implement digital solutions to support real-time decision-making and operational flow.

4.4 **Capital and Operational Investment:** There is no additional revenue funding to support winter planning and response. Over **£370 million** is being allocated nationally to:

- Develop ~40 new Same Day Emergency Care (SDEC) units and Urgent Treatment Centre's (UTCs).
- Increase mental health crisis and inpatient capacity.
- Expand Connected Care Records to all ambulance trusts.

4.5. **Winter Assurance Summary:** In line with the national assurance template, local systems are required to provide assurance against several areas of concern, aligned to their organisational role.

4.6 **Integrated Care Boards (ICBs):** ICBs are asked to provide assurance on:

- **System Leadership**: Oversight of system-wide winter planning and delivery, including coordination with acute, community, mental health, and local authority partners.
- **Vaccination and Resilience Planning**: Plans for flu/RSV vaccination, infection prevention control, and winter virus surge management.
- **Community Capacity**: Expansion and effective use of community beds, urgent community response, and virtual wards.
- **Discharge Governance**: Alignment with Better Care Fund (BCF) goals, performance targets for discharge, and reduction of 21+ day delays.

4.7 **Acute Trusts**: Acute Trusts must provide assurance on:

- **UEC Delivery Standards**: Delivery of the 4-hour A&E standard and implementation of the Release to Rescue 45-minute handover model.
- **Flow and Capacity**: Use of UTCs and SDECs, minimisation of corridor care, and clear discharge planning pathways.

- **Workforce and Safety**: Staff vaccination, IPC protocols, clinical leadership models, and availability of specialty input within 72 hours of admission.
- **Digital Adoption**: Use of real-time digital dashboards and forecasting tools (e.g. NHS Federated Data Platform) to manage demand.

4.8 **Mental Health Trusts:** Mental Health providers are expected to assure:

- **Crisis Alternatives**: Availability and operational readiness of crisis assessment Centre's and alternatives to ED attendance.
- **Timely Admission**: Reduction of >24-hour waits for mental health beds and active reduction in out-of-area placements.
- **Discharge and Flow**: Use of high-impact actions to support timely discharge and reduce re-admissions among high-intensity users.
- **System Integration**: Active participation in wider UEC planning and support for EDs managing mental health attendances.

4.9 Cheshire & Merseyside Approach:

- the Cheshire and Merseyside Urgent and Emergency Care Programme consists of five locality programmes, and cross cutting at scale schemes. This structure was established in 2024/25 and has remained the organising principle for our 2025/26 UEC improvement plans.
- in keeping with the principle of five localities, C&M will set our winter plans at locality and ICB level.
- the winter planning process will be managed through the 5 UEC Locality SROs, who will each produce a single plan for their area.
- in developing this plan, Locality SROs will engage and work with providers and system partners to develop their winter plan tailored to population needs and operational capacity.
- SMEs have been identified to support review and development of the key lines of enquiry (appendix 1)
- these will be underpinned by shared system actions and escalation principles. It is critical that all system partners are involved in the development of and therefore the ongoing ownership of the plan.
- an overarching ICB plan will then be articulated and submitted to NHSE, ahead of national and local testing of plans in the autumn.
- in line with the UEC plan, there is an expectation that each Trust will identify an SRO for Winter who will oversee winter planning and operations across the period.
- at a locality level, SROs are identified as leads for winter and at a system level, the role of ICB winter director will be taken up by the Director of Planning and Performance.

4.10 Key dates and timeline:

- 11 July: Trusts to submit 1st cut winter plans to locality SROs and through local governance
- 17 July: SROs to submit locality plans to central ICB planning team
- 21 July: Submission of 1st cut system plan to NHSE North West
- 4-8 August Feedback to localities from ICB / NHSE
- 21 August: SROs to submit 2nd cut winter plans to central ICB planning team

- 1-5th Sept: C&M Locality winter stress testing by ICB & SME's
- September (TBC): Stress-testing of winter plans through NHSE hosted exercise
- 24 September: Board to discuss and consider final sign off
- 30 September: Submission of Board Assurance Statement to NHSE National UEC team.

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

5.1 The winter planning process and delivery of the winter response are most relevant to the following ICB Strategic Objectives:

Objective One: Health Inequalities in access, outcomes and experience
Objective Two: Improving Population Health and Healthcare

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

6.1 Urgent Care Improvement is one of the four top priorities set out in our Annual Delivery Plan for 2025/26. This is supported by plans to address Admission Avoidance, In Hospital Flow, Discharge, Ambulance Improvement, Urgent and Emergency Care at Scale and Mental Health System Flow. The winter planning process links directly to the achievement of this objective.

7. Link to meeting CQC ICS Themes and Quality Statements

7.1 The winter plans link to all three CQC ICS themes and quality statements, in that the key national metrics set out in NHS England's *Urgent and Emergency Care Plan 2025/26* are key to the delivery of quality and safety along the UEC patient pathway, and the focus of the winter planning is precisely on the leadership and integration required to deliver this.

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

8. Risks

- The winter planning process is most pertinent to Board Assurance Framework Risk P15: *There is a risk that the system will be unable to deliver timely and effective urgent and emergency care services due to rising demand, workforce pressures, capacity constraints, and delayed patient discharges. This may result in non-compliance with key NHS 2025/26 planning guidance standards, including the 4-hour ED target, 12-hour decision-to-admit (DTA) breaches, and ambulance handover delays. These*

risks may contribute to patient harm, regulatory scrutiny, and reputational damage.

- The winter plan will be a key control against this risk, along with the wider UEC Programme.

9. Finance

9.1 There is no additional revenue funding outside of normal allocations to support winter preparations and the winter response.

10. Communication and Engagement

10.1 Locality SROs will engage and work with providers and system partners to develop their winter plan tailored to population needs and operational capacity. In due course a wider communications and engagement plan will need to developed.

11. Equality, Diversity and Inclusion

11.1 n/a

12. Next Steps and Responsible Person to take forward

12.1 All systems are required to submit their finalised winter plans and assurance templates by summer 2025. NHS Boards are expected to:

- provide oversight of risk-rated areas and escalate any concerns
- confirm that plans are supported by clear operational leads and clinical governance.
- ensure local delivery is aligned with national performance priorities and investment streams.
- a further update will be provided to the Board in September 2025, following the planned regional stress-testing of winter plans.

13. Officer contact details for more information

Responsible Director: Anthony Middleton, Director of Performance & Planning

Responsible Officers: Claire Sanders Associate Director of Urgent & Emergency Care Operations and Improvement

14. Appendices

Appendix One: List of SME's for winter planning

Appendix One: List of SME's for winter planning

KLOE	Contact
Patient Safety and risk	Place Associate Directors of Quality
Vaccination and wider prevention	**Julie Kelly,** Associate Director of Population Health
IPC	Place Associate Directors of Quality
Leadership and control	**Fiona Lemmens**, Deputy Medical Director, **Chris Douglas**, Director of Nursing & Care, **Claire Sanders**, Associate Director UEC Operations & Improvement
Primary care and Community	**Chris Leese,** Associate Director of Primary Care
Mental health	**Simon Banks**, Strategic Lead Mental health, Learning Disability & Autism **Claire James**, Mental Health Programme Director
Workforce	**Emma Hood**, Workforce training & Education Transformation lead
Children and Young people	Place ADQs
Health Inequalities and prevention	**Ian Ashworth**, Director of Population Health
EPRR and System Resilience	**Nicola Barnes**, Interim Head of Emergency Preparedness

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

Seasonal Vaccinations: 2024/25 look back and plans for 2025/26 with a spotlight on improving vaccination uptake in Health Care Workers

Agenda Item No: ICB/07/25/18

Responsible Directors: Professor Ian Ashworth, Director of Population Health
Dr Fiona Lemmens, Associate Medical Director for Transformation and Deputy Medical Director

Seasonal Vaccinations: 2024/25 look back and plans for 2025/26 with a spotlight on improving vaccination uptake in Health Care Workers

1. Purpose of the Report

1.1 The Winter of 2024/ 25 saw major incidents declared in response to multiple Cheshire and Merseyside NHS Trusts experiencing significant operational pressures with reports of high cases of Seasonal Influenza (Flu) and other respiratory illnesses in both staff and patients contributing to winter pressures.

1.2 Many infectious diseases, particularly respiratory diseases, are more prevalent in winter and this adds pressure on systems that are already stretched during the peak winter season. Vaccination can be a highly effective means of mitigating that risk.

1.3 The ICB Board asked for a report on Seasonal Vaccinations to come to the July 2025 Board meeting with a spotlight on Health Care Worker uptake and how the ICB can best support improvements in uptake rates as part of wider winter planning efforts ahead of the 2025/ 26 season.

1.4 The report briefly considers the uptake rates in the eligible population for Seasonal Flu, Covid-19 and RSV vaccinations. The report also considers the uptake in Health Care Workers (HCW) by NHS Trusts in 2024/ 25 for Flu and Covid-19 and focusses on what can be done to improve this in 2025/ 26.

1.5 It considers the key findings and themes of insight work commissioned by the ICB with HCWs from both primary and secondary care and from domiciliary staff in relation to what influenced their vaccination choice in 2024/ 25.

1.6 The report concludes with work to date to improve HCW uptake ahead of the 2025/ 26 winter season. It asks for support from the ICB Board and its Partner Members in adopting a systemwide approach to making seasonal vaccination uptake improvements with some specific actions from system partners.

2. Executive Summary

2.1. NHS England are the commissioners of all routine vaccination programmes including seasonal vaccinations. Recent data indicates a significant decline in seasonal vaccination rates in the UK across all eligible cohorts compared to pre Pandemic levels. Seasonal vaccinations can save lives and keep communities healthier and more productive. In order to improve uptake a system wide response is needed.

2.2. NHS Cheshire and Merseyside is able to provide additional leadership in this space. The ICB is well placed as both a strategic commissioner and system

convener to bring together Providers from both primary and secondary care to ensure that their commitment can be secured to improving seasonal vaccination uptake rates for both patients and staff.

2.3. Over the last six years the overall uptake for Health Care Workers in NHS Trusts in Cheshire and Merseyside has seen a year-on-year decline from 82.5% in 2019/20 to 41.4% in 2024/25. There is wide variation between Providers and no Provider in Cheshire and Merseyside improved on their 2023/ 2024 uptake for staff with almost all seeing a decline.

2.4. NHS Cheshire and Merseyside have recently commissioned insight work with Health Care Workers to ascertain what shaped their views about whether or not to accept the Covid-19 and/ or Flu vaccination in 24/ 25. The work identified barriers, motivators, and information gaps. The role of strong, visible senior leadership can not be under-estimated. The key enablers are as follows:

- Increase Capability – address knowledge gaps and misconceptions
- Increase Vaccination Opportunity – improve access, convenience and social norms
- Increase Motivation – rebuild trust, share positive stories, offer incentives

2.5. It is the ICBs expectation that all Providers will act on the findings of the insight work and develop credible plans with agreed trajectories for improvement to ensure their staff uptake rate improves on last years.

2.6. Vaccinations save lives and should be a key driver to protect our population's health forming a key strand of winter planning. NHS England has written to all Providers and system leaders in recent weeks about their Flu plans. NHS Cheshire and Merseyside are well placed to support ensuring we are as prepared as we can be as a system ahead of winter 25/ 26.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **ENDORSE** the need for a co-ordinated and systemwide response from the ICB, primary care, secondary care, specialist trusts and Local Authorities to improving seasonal vaccination uptake in all eligible groups, including health care workers and domiciliary staff

- **ENDORSE** that NHS Providers develop staff vaccination plans which act on the recommendations of the ICB commissioned Health Care Worker insight work

- **APPROVE** regular flu vaccination uptake reporting to ICB Board meetings throughout winter 2025/ 26 in line with requirements in NHS England » Urgent and emergency care plan 2025/26 to ensure a continued focus.

4. Reasons for Recommendations

4.1 Vaccination can be a highly effective means of mitigating some of the risks associated with winter pressures. Data shows that whilst improvements have been made in some of the eligible population, uptake of seasonal vaccinations in some groups, including Health Care Workers, has been declining over recent years particularly when compared to pre-Pandemic levels.

4.2 Without concerted systemwide commitment to address this there is an increased risk of both poorer health in the population and additional burden placed on the health and social care system this winter.

5. Background and overview

5.1 Seasonal vaccinations can save lives and keep communities healthier. Vaccination can be a highly effective means of mitigating some of the risks associated with winter pressures because they:

- protect individuals from illness, significantly reducing their likelihood of infection and the need for hospital care
- reduce the severity of illness if they do become infected
- help to protect vulnerable populations
- in some cases, reducing rates of transmission, including from infected individuals who show no symptoms
- can help to reduce pressures on the health service
- keep the workforce well and able to continue to be productive and care for others.

5.2 NHS England are the commissioners of all routine vaccination programmes including seasonal vaccinations. Whilst there have been improvements in uptake in some eligible cohorts, data indicates a decline in vaccination rates in England especially compared to pre Pandemic levels.

5.3 **Seasonal Flu vaccination** - Published seasonal Flu data can be found at: Seasonal influenza vaccine uptake in GP patients: winter season 2024 to 2025 - GOV.UK

5.4 The Flu vaccination programme is well established; over recent years vaccination rates have been steadily declining in the UK across several key groups. Local analysis shows that whilst there were improvements in Flu vaccination uptake in Cheshire and Merseyside between 2023/ 24 and 2024/ 25, more work is needed to ensure all of the eligible population are vaccinated.

5.5 There is significant variation between Places and Primary Care Networks with the lowest rates/ numbers of unvaccinated residents living in some of our most deprived populations. For example, one of our most deprived Places had

uptake in the 65s and over of 65.8% compared to 79.8% in one of the most affluent parts of the patch.

5.6 Data published by the UK Health Security Agency (UKHSA) Flu vaccine prevented around 100,000 hospital admissions - GOV.UK showed that the flu vaccine is estimated to have prevented around 96,000 to 120,200 people from being hospitalised in England last winter. But for many thousands of unvaccinated vulnerable children and adults who ended up seriously ill in hospital, this could have been prevented.

5.7 The cumulative hospital admission rate in 2024/ 2025 season was 139.5 per 100,000; this was higher than the 2023 to 2024 season (77.5 per 100,000) and for excess mortality, there were 7,757 deaths over winter 2024/ 2025; this is higher than the 3,555 deaths recorded for the previous winter.

5.8 **Covid-19 vaccination** – Published seasonal Covid-19 data can be found at: Statistics » Vaccinations: COVID-19. The UK Covid-19 vaccination programme was introduced in 2020; the last 3 years has seen a year-on-year reduction in the numbers of people eligible taking up a Covid-19 vaccination in Cheshire and Merseyside:

- Autumn/ Winter 2022: 62.2% uptake
- Autumn/ Winter 2023: 53.5% uptake
- Autumn/ Winter 2024: 42.4% uptake.

5.9 As with Flu, there is significant variation between Places in relation to the Covid-19 vaccination, with the lowest rates/ numbers of unvaccinated residents living in some of our most deprived populations. The lowest uptake at Place level for Autumn/ Winter 2024 was 28.0% compared to the highest Place of 54.5%, almost double

5.10 **Respiratory syncytial virus (RSV) vaccination** – Published RSV vaccination data can be found at: Statistics » Vaccinations: RSV. NHS England introduced the RSV vaccination programme for adults aged 75 – 79 and pregnant women in September 2024. RSV is a major cause of respiratory illness, particularly dangerous for infants and the elderly. Whilst not strictly seasonal, the virus is common between November to February, and can lead to pneumonia and infant bronchiolitis, requiring hospitalisation and intensive care in severe cases.

5.11 The catch up (older) cohort is the most complete dataset and Cheshire and Merseyside ICB has so far achieved 60.8%, the highest uptake in the North West compared to 59.1% and 59.7% compared to neighbouring ICBs. It will be at least 12 months before there is a complete dataset of the other cohorts as the programme only began in September 2024.

5.11. **Flu and Covid-19 vaccination uptake in Health Care Workers –** Published data can be found at: Final-Autumn-Winter-2024-25-Flu-vaccinations-to-FHCWs-31-March-2025.xlsx

5.12. Over the last six years the overall uptake for HCWs in NHS Trusts in Cheshire and Merseyside has seen a year-on-year decline from 82.5% in 2019/20 to 41.4% in 2024/25. As described in Table 1, there is wide variation between Providers. No Provider in Cheshire and Merseyside improved on their 2023/ 2024 uptake for staff with almost all seeing a decline.

5.13. The ICB is committed to reversing this trend of declining vaccination rates in staff. The recently published NHS England » Urgent and emergency care plan 2025/26 advises that all Trusts must strive to achieve an improvement of at least 5% for staff uptake on last years rates.

Table 1: Cheshire and Merseyside frontline healthcare worker influenza vaccination in England: 1 September 2024 to 31 March 2025, DPS (Data Processing Service) Direct Flow, NHS England, 10 July 2025

Trust Name	FDP Active FLHCW uptake 24/25 campaign	25/26 ambition +5%
Liverpool Women's NHS Foundation Trust	32%	**38%**
Mersey Care NHS Foundation Trust	33%	**37%**
Liverpool University Hospitals NHS Foundation Trust	35%	**40%**
The Clatterbridge Cancer Centre NHS Foundation Trust	35%	**40%**
Liverpool Heart and Chest NHS Foundation Trust	37%	**42%**
Alder Hey Children's NHS Foundation Trust	42%	**48%**
Cheshire and Wirral Partnership NHS Foundation Trust	43%	**48%**
Mersey and West Lancashire Teaching Hospitals NHS Trust	43%	**47%**
Countess of Chester Hospital NHS Foundation Trust	45%	**50%**
Warrington and Halton Hospitals NHS Foundation Trust	45%	**50%**
Mid Cheshire Hospitals NHS Foundation Trust	46%	**51%**
Wirral Community Health and Care NHS Foundation Trust	47%	**52%**
The Walton Centre NHS Foundation Trust	47%	**52%**
Wirral University Teaching Hospital NHS Foundation Trust	50%	**55%**
Bridgewater Community Healthcare NHS Trust	53%	**58%**
East Cheshire NHS Trust	56%	**61%**
Totals	**41.4%**	**46.4%**

5.14. Earlier this year NHS Cheshire and Merseyside commissioned ICE behavioural insight specialists to explore the reasons behind the low uptake of winter vaccinations among staff and identify potential strategies to drive uptake among our workforce in 2025/ 26

5.15. Over 1500 local staff working in primary care, secondary care, specialist Trusts and domiciliary care participated and gave their feedback. In addition to this, interviews were undertaken with senior leaders and clinicians responsible for staff vaccination in local Providers and some ICB Board members experienced in leading seasonal vaccination campaigns in their own organisations. We are extremely grateful to everyone who shared their insights with us.

5.16. The top 3 drivers of uncertainty for taking up both Flu and Covid vaccinations are as follows:

- Worry about side effects

- Not sure it makes a difference
- I want to make my own health choices without feeling pressured.

5.17. What staff said they need to positively influence their decision to be vaccinated:

- Provide information to reassure and address myths and misconceptions
- Ensure information about vaccines is publicly available, and staff know who to speak with
- Be transparent about the side effects of vaccination e.g. fatigue
- Ensure information comes from trained staff
- Visible infection rates: seeing more patients, colleagues, or loved ones affected can prompt a sense of duty to protect others
- Incentives: small perks like tea and a biscuit can encourage vaccination
- Use trusted messengers: staff prefer vaccine information from sources they trust, such as the NHS
- Rebuild trust through listening and transparency
- Acknowledge past mistakes and decisions about the vaccine
- Improve access by giving advance notice of vaccine dates, offering on-site drop-in sessions and bringing vaccinations to staff
- Allow more time for staff to get the vaccine e.g. by protecting time for them to leave the ward or the office
- Social norms: if more people, including colleagues and family, get the vaccine and talk openly about it
- Highlight stories about people getting vaccines – coming from people staff can relate with.

5.18. A key piece of insight was how many staff members cited the impact their work has on their loved ones and the importance of getting vaccinated to protect themselves, their patients and their own loved ones, including children. Whilst not the focus of this work, there will be a focussed effort on improving seasonal Flu vaccination uptake in children and young people and in particular 2 and 3 year olds. This is because younger children are at higher risk of serious illness from Flu and they can spread Flu to others – especially older or vulnerable people.

5.19. In order to improve uptake we must both act on the findings of this local insight work and ensure a system wide response. Whilst NHS England are the commissioners of vaccination programmes, NHS Cheshire and Merseyside is able to provide additional leadership in this space. Our insight has been shared with the national NHSE team who are working together with Trust colleagues on national communication assets to make the HCW winter vaccinations campaign as successful as it can be.

5.20. The ICB has already secured previous support from Trust Chairs and Medical Directors earlier this year to actively promote vaccination uptake amongst staff. All Trusts are required to submit staff vaccination plans as part of winter planning requirements and we will work with NHS England North West to ensure these plans are developed and delivered for maximum impact.

5.21. It is the ICBs expectation that all Trusts will act on the findings of the insight work to ensure their campaign is more successful than last and considers a range of delivery models for example, pop up vaccination clinics, roving models, voucher schemes for use in community pharmacies and vaccination must also be available for staff who work at evenings and weekends. As a minimum, plans should demonstrate the following:

Increasing Capability
- Provide clear, credible Information
- Address misconceptions and knowledge gaps
- Enable informed, personal conversations.

Increasing Opportunity
- Increase convenience and access
- Clearly communicate the vaccine clinics in good time
- Promote vaccine choice
- Use peer influence and relatable stories to make vaccination the 'norm'

Increasing Motivation
- Emphasis autonomy and shared values
- Use real stories and local data
- Listen and co-create
- Offer incentives like a cup of tea and a biscuit.

Rebuilding trust
- Acknowledge past mistakes
- Deliver a sensitive and timely message
- Create space for reflection and dialogue
- Strengthen two-way communication between leadership and staff
- Acknowledge broader pressures.

5.22. Trajectories for staff vaccination will be agreed with each Trust which must have a 5% improvement target on last years uptake rate as a minimum. For some of the poorest performing Trusts, based on last years uptake it is expected that they will need to set an improvement trajectory greater than 5%. The ICB will work closely with NHS England throughout the season to measure progress and offer additional support where plans are moving away from trajectory. Each Trust is expected to have a nominated Executive Lead for this work.

5.23. Agreement has been secured from NHS Communications leads from across the North West to work together on a co-ordinated campaign to improve vaccination uptake in Health Care Workers using the intelligence from our local insight work.

5.24. We will work with our Primary Care Place leads and Local Medical Committees to improve uptake of vaccination in all eligible populations including frontline staff in primary care. We also work with Community Pharmacy partners.

5.25. We will share the findings of our insight work with Health Protection leads in Local Authority Public health teams and with Directors of Adult Social Care to help improve vaccination uptake rates in social care staff and secure their commitment to support this work in their own organisations and sector.

5.26. Our VCFSE sector is also crucial to supporting key messages and intervention in promoting the importance of seasonal vaccinations within their networks and social prescribing network links.

5.27. The ICB is well placed as both a strategic commissioner and system convener to bring together partners from across the system to ensure that their explicit commitment can be secured to improving seasonal vaccination uptake rates for both patients and their staff. The importance of strong and visible leadership in this space cannot be under-estimated and is essential to help reverse the declining trend in uptake rates,

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

People living in the 20% most deprived areas in England are almost twice as likely to be admitted to hospital due to both infectious diseases and respiratory disease than the least deprived.

Objective Two: Improving Population Health and Healthcare

Vaccinations protect individuals from illness, significantly reduce their likelihood of infection and the need for hospital care.

Objective Three: Enhancing Productivity and Value for Money

Vaccinations can help to keep the workforce well and able to continue to be productive and care for others.

Objective Four: Helping to support broader social and economic development

Vaccinations can keep whole communities well and more resilient.

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

7.1. Screening and Immunisations is one of the four key pillars of our Cheshire and Merseyside Population Health Programme.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety

- QS1: Supporting to People to live healthier lives
- QS2: Learning culture

Theme Two: Integration

- QS9: How staff, teams and services work together

Theme Three: Leadership

- QS10: Shared direction and culture
- QS11: Capable, compassionate and inclusive leaders
- QS14: Partnerships and communities
- QS15: Learning, improvement and innovation

9. Risks

9.1. There is a risk that if those who are eligible for seasonal vaccinations do not take up the offer that additional burden may be placed on individuals, our communities and on our health and social care system.

10. Finance

10.1. No additional finance is sought to approve the recommendations in this report. However, it should be noted that improved seasonal vaccination uptake rates in both the eligible populations and staff could result in a reduced financial burden on the health and social care system due to reduced hospital admissions and staff absence. As detailed in Section 5, the flu vaccine is estimated to have prevented around 96,000 to 120,200 people from being hospitalised in England last winter.

11. Communication and Engagement

11.1 Extensive engagement has been undertaken with frontline health care workers and domiciliary staff as described.

12. Equality, Diversity and Inclusion

12.1. As described in the report vaccination uptake rates are lowest in our most deprived communities and those who live in the most deprived parts of our community are more likely to be admitted to hospital with a respiratory illness.

12.2. Trust plans will need to address health inequalities as per winter planning expectations

13. Next Steps and Responsible Person to take forward

13.1. NHS Cheshire and Merseyside will continue to work with system partners to ensure co-ordinated, evidence based plans are developed and delivered to improve seasonal vaccination uptake.

13.2. The findings of the Health Care Worker insight work will be used to further develop plans for the 2025/26 season.

13.3. The responsible officer for taking forward any actions or queries following Board consideration is Julie Kelly, Associate Director of Population health

14. Officer contact details for more information

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NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

Update on improving access to Primary Medical (General Practice) Services

Agenda Item No: ICB/07/25/19

Responsible Director: Clare Watson, Assistant Chief Executive

Update on improving access to Primary Medical (General Practice) Services

1. Purpose of the Report

1.1 To update the Board on:

- a summary of current plans for improving access to general practice for 25/26 in response to national policy asks - outlined within the operational planning guidance.
- feedback from two key patient experience surveys which will be presented at the Board in summary form, as part of this agenda item.

2. Executive Summary

2.1 The Board had previously agreed an Access Improvement Plan (including 9 individual place improvement plans) in November 2023, in response to policy asks within the 'Recovering Access to Primary Care' document https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/ which was a 2 year framework. Progress against these plans were also presented to Board in March and November 2024. It was noted at the last update that further policy asks were awaited to frame our subsequent approach for 25/26 and beyond.

2.2 Board feedback had previously highlighted the importance of patient experience feedback on measuring the impact of the 2023 improvement plan - and supported further work being undertaken by local Healthwatch teams to understand the impact of actions outlined at both place and system level. Healthwatch are in attendance at the Board to present a summary of their findings in this respect.

2.3 For 2025/26, under the operational planning guidance NHS England » NHS operational planning and contracting guidance, one of the key themes for general practice remained access improvement – with ICBs expected to continue to support general practice to enable patients to access appointments in a more timely way and continue to improve patient experience. This priority was also highlighted in the recent 10 Year Plan documentation.

2.4 The main ask of ICBs for 25/26, in addition to delivery of the above, is to outline actions to improve contract oversight, commissioning and transformation for general practice, and tackle unwarranted variation – consolidated into a single plan to be submitted to NHS England by 23 June 2025. This plan was approved at the June 2025 meeting of the System Primary Care Committee and submitted by the deadline.

2.5 The plan follows outlines actions to support the following asks:

- **How the ICB will address unwarranted variation** by using more consistent sets of date and patient experience feedback/insight at individual practice and strategic ICB level to improve access against agreed plans.

- **General actions to improve contract oversight** including any work to review contracts, contract management and governance to reduce variation in approach.

- **Actions to support commissioning and transformation** using outcomes from any internal assessment/developments, cross referencing to areas such as neighbourhood health development.

- **Maximising key enablers that deliver modern general practice**, such as digital tools, estates, funding pools and services such as pharmacy first.

2.6 Examples of specific actions outlined as part of the 'June' plan include:

- Utilisation of the new national GP Dashboard which contains performance domains including 'Access and Experience' and other data sources to support targeted variation work with specific practices including developing commissioner led improvement plans where appropriate. There has already been an initial enquiry from NHS England nationally, in relation to assurance of ICB actions where data has flagged specific outliers.

- Using data to further support cross ICB single strategic measures in certain areas - and actions in relation to population health data, including further targeted work in some of our most deprived wards.

- The data sets that support the above are given in Appendix One. The national reporting and data expected , with any improvement areas, are currently awaited from NHS England. The June plan details how these sets of data and others, are used and applied, for example – to identify variation and follow up.

- Offering further support for practices under the Practice Level Support scheme (PLS), with a mixture of targeted referrals, using data sources outlined above - and practices who are requesting support for particular challenges.

- How the ICB will use key contract levers, such as on- line consultation availability within core hours – and risk stratification tools - to further support maximisation of all options for patients to access appointments and a more streamlined patient journey.

- Key actions to support the ICB in reviewing its primary medical contracts and commissioning work to align to a more consistent single approach. A new contracting and commissioning oversight group is in place to oversee this and single templates / frameworks in progress.

- Actions to further embed transformation, sharing success and improvement across practices were outlined, linking to general practice's crucial role in Neighbourhood Health and the modern general practice workstream, including maximisation of key digital tools that support improved access.

- Governance and oversight– the plan will be overseen and reported on by exception from the oversight group to the System Primary Care Committee.

2.7 A further key area of the plan was to ensure patient experience feedback is used to assess progress and inform future actions. This includes information contained with the national GP patient survey – the 2025 survey results were released this month GP Patient Survey - a short summary of the key 2025 results and themes will be presented to the Board at this meeting. Together with the local Healthwatch survey results, also presented, this gives the ICB important feedback from patients, to help shape future planning and areas where further focus is required – which will be highlighted in the presentation(s).

3. Next Steps

3.1 The ICB is currently awaiting further feedback from NHS England following the 23 June 2025 submission – the final plan with any requested amendments will then return to the System Primary Care Committee as part of the oversight and governance actions moving forward.

3.2 NHS England have already flagged that development of the plans for individual practices requiring more intensive contractual oversight and support will still be seen as pending, as at June submission. Further assurance will be sought by NHS England on those individual plans. The ICB is also currently awaiting the national reporting data set that will be used by NHS England to assess progress.

3.3 The risks and mitigations in the plan will be developed into a separate risk register and managed through the oversight group, reported by exception to the System Primary Care Committee.

3.4 The key areas of the plan and the patient experience feedback presented today will be mapped against the asks in the '10 Year Plan' and any subsequent primary care specific follow on guidance nationally - to produce a revised access improvement strategy for primary medical services.

4. Ask of the Board and Recommendations

4.1 The Board is asked to:

- discuss and note the update on the access to general practice (primary medical) services plans for 25/26.
- discuss and note the patient experience feedback presented.

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

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

6. Link to meeting CQC ICS Themes and Quality Statements

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

7. Risks

6.1 Risks are detailed in the paper appendices but support the following BAF risks ;

- P6.

8. Finance

7.1 No finance decisions are required but funding areas have been discussed in context at System Primary Care Committee.

9. Communication and Engagement

8.1 Further communication and engagement work will be required for the final plan.

10. Equality, Diversity and Inclusion

9.1 An updated Equality and health inequality analysis will be required for the revised plan.

11. Officer contact details for more information

Christopher Leese, Associate Director of Primary Care
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12. Appendices

Appendix One: National GP Dashboard (Current) Data Set

Appendix One

National GP Dashboard (Current) Data Set (note more indicators will be added to this)

Domain	Metric Definition
GP Access and Experience	Number of general practice appointments per 1,000 registered (NHS England allocations - Annex J) patients
GP Access and Experience	The percentage of appointments not usually booked in advance seen with 14 days of booking
GP Access and Experience	The percentage of patients describing their overall experience of their GP practice as "very good" or "good"
GP Access and Experience	The percentage of patients describing their overall experience of contacting their GP practice on this occasion as "very good" or "good"
GP Access and Experience	Rate of online consultations per 1,000 patients registered at practices known to have an online consultation system
GP Clinical Outcomes and Care Quality	Percentage of new cancer cases treated that were first diagnosed following an urgent suspected cancer referral
GP Clinical Outcomes and Care Quality	The percentage of patients on the QOF Learning Disability register (aged 14 years or over) who received a learning disability health check between the start of the financial year and the end of the reporting period
GP Clinical Outcomes and Care Quality	The percentage of people with Severe Mental Health Issues (SMI) to receive the complete list of physical health checks in the preceding 12 months
GP Workforce	Number of registered patients per GP Full-Time Equivalent (FTE) (NHS England allocations - Annex J) patients
GP Workforce	Number of registered patients per Fully Qualified GP Full-Time Equivalent (FTE) (NHS England allocations - Annex J) (NHS England allocations - Annex J) patients
GP Workforce	Number of registered patients per Nurse Full-Time Equivalent (FTE) (NHS England allocations - Annex J) patients
GP Workforce	Number of registered patients per Admin Full-Time Equivalent (FTE)(NHS England allocations - Annex J) patients
GP Workforce	Number of registered patients per Direct Patient Care (DPC)-Collated (FTE) (NHS England allocations - Annex J) patients

Domain	Metric Definition
GP - Vaccination and Screening	% Child Imms DTaP/IPV/Hib/HepB (age 1 year)
GP - Vaccination and Screening	% Child Imms Hib/MenC booster
GP - Vaccination and Screening	% Child Imms MMR (Age 2 yrs)
GP - Vaccination and Screening	% Child Imms PCV Booster
GP - Vaccination and Screening	Cervical Screening Age 25 to 49 & Cervical Screening Age 50 to 64
GP Clinical Outcomes and Care Quality	Overall QOF achievement
GP Clinical Outcomes and Care Quality	QOF - Diabetes Mellitus. The % of patients with diabetes, on the registers, without moderate or severe frailty with Hba1c reading
GP Clinical Outcomes and Care Quality	The percentage of patients with COPD on the register, who have had a review in the preceding 12 months
GP Clinical Outcomes and Care Quality	The % of patients with diabetes without with moderate or severe frailty with an HBA 1C <75 T2DM
GP Clinical Outcomes and Care Quality	QOF - The % of patients diagnosed with dementia with care plan review

Domain	Metric Definition
GP Access and Experience	Percentage of Appointments with a GP
GP Clinical Outcomes and Care Quality	CQC Overall Practice Rating

Domain	Metric Definition
GP Clinical Outcomes and Care Quality	CVD- Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatmentthreshold

ICB Primary Care (Local) Scorecard Data Set

Area	Metric
Access	Appointment rate per 1,000 population
Access	% Face to Face appointments
Access	% Same Day appointments
Access	% GP Led appointments
Demographics	List Size
Demographics	IMD Score (Average)
Demographics	Female Life Expectancy (Average)
Demographics	Male Life Expectancy (Average)
Improving Quality	CQC (Inspection) Rating
Patient experience	Friends and Family - No submissions last 3 months
Patient experience	Friends and Family - % recommended
Patient experience	GP Survey Response Rate
Patient experience	Good Experience when contacting GP Practice %
Prevention and Screening	% MMR 1 @ 2 Years
Prevention and Screening	% MMR 1 @ 5 Years
Prevention and Screening	% MMR 2 @ 5 Years
Prevention and Screening	Bowel Screening Rate
Prevention and Screening	Breast Screening Rate
Prevention and Screening	Cervical Screening Coverage (Age Group 25 To 49)
Prevention and Screening	Cervical Screening Coverage (Age Group 50 To 64)
Prevention and Screening	Flu Vaccination 2 to 5 year olds
Prevention and Screening	Flu Vaccination 65 & Over
Prevention and Screening	Learning Disability Health Checks for 14+
Prevention and Screening	SMI Annual Review
Quality Outcome Framework	QOF PCA Rate (All Domains)
Effective use of resources	(All) AE Rate per 1,000 - (Yearly)
Effective use of resources	Emergency Admission rate per 1,000 - (Yearly)

Area	Metric
Effective use of resources	Emergency Admissions ACS Chronic rate per 1,000 - (Yearly)
Effective use of resources	Emergency Admissions ACS Acute rate per 1,000 - (Yearly)
Effective use of resources	GP Referred 1st OP rate per 1,000 - (Yearly)
Workforce	GP WTE rate per 1,000
Workforce	Nurse WTE rate per 1,000
Workforce	Admin WTE rate per 1,000
Workforce	DPC WTE rate per 1,000

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

ICB 2025-26 Annual Delivery Plan

Agenda Item No: ICB/07/25/20

Responsible Director: Clare Watson
Assistant Chief Executive

ICB 2025-26 Annual Delivery Plan

1. Purpose of the Report

1.1 The Board approved a high-level summary version of the 2025/26 Cheshire and Merseyside Delivery Plan at the board on the 27 March 2025 which was published as required on the 31 March 2025. This approach was in line with the suggested national approach to update Five Year Joint Annual Forward Plans.

1.2 It remains the intention to delay a full refresh of our Joint Forward Plan until after further national information in relation to the delivery approach to the recently published NHS 10 Year Plan and future NHS operating model are clarified alongside undertaking a more detailed analysis of the implications of these changes alongside current local priorities including ongoing development of our financial sustainability and system improvement programme. As this information becomes available the content of our plan will be refined.

1.3 The Plan approved in March identified four headline priority areas for 2025-26:
1. Financial Sustainability
2. Urgent Care Improvement
3. Planned Care
4. Neighbourhood and Population Health.

These are supported by 6 Strategic and Enabling programmes (see the diagram below in 2.2).

1.4 The report aims to provide the Board with more details on the current plans and priorities in these key programmes that will deliver our organisational priorities. The report highlights the nationally set ***'must do'*** areas which will be reported to the Board through the Integrated Performance Report alongside key programme measures, defined metrics and the quarterly trajectories being used to monitor progress through our Board sub committees and wider governance arrangements.

2. Executive Summary

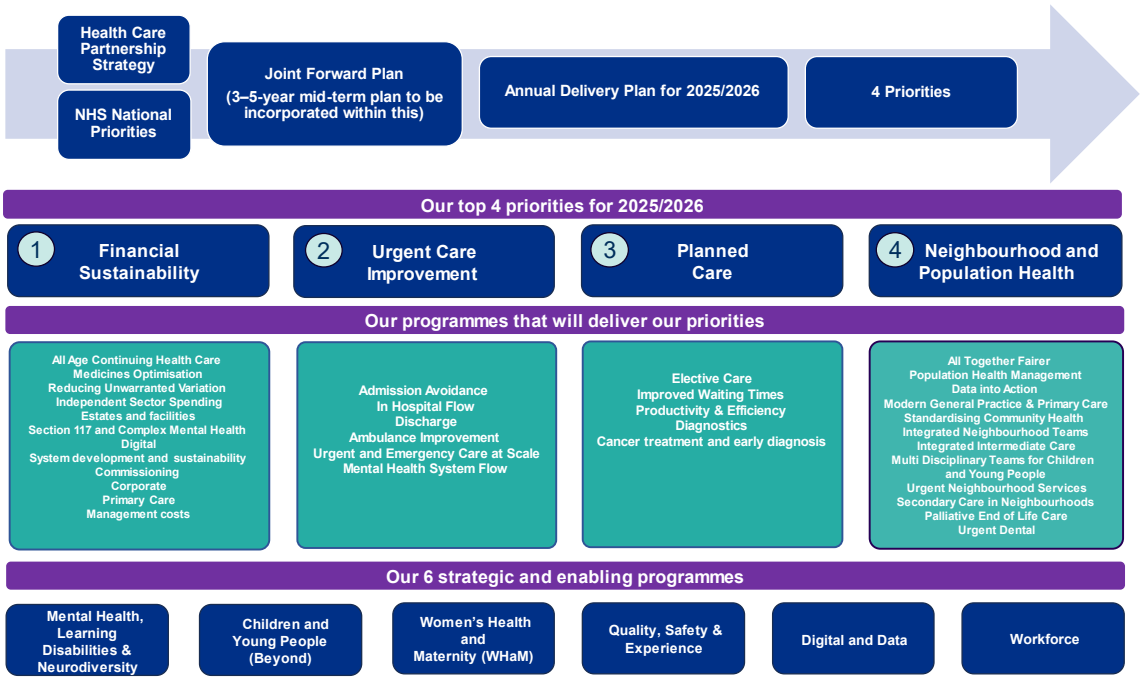
2.1 In recent years we have used our annually refreshed Joint Forward Plan to describe our key priorities. The Board on the 27th of March and in line with the suggested national approach, and in reflection of the delayed publication of the NHS 10 Year Plan, agreed to delaying re-publication of a full Joint Forward Plan until after this.

2.2 The role and functions of the ICB will change to reflect the revised NHS operating model and it is reflected the focus will more specifically relate to strategic commissioning focusing on improving population health and developing neighbourhood health models, and to optimise this will require

further organisational development. 2025-26 will be a transitional year as implementation arrangements for these national plans develop.

2.3 The publication of the ICB Annual Delivery Plan refresh for 2025-26 was published on the ICB website on the 31 March 2025 and consisted of an outline of the following:

- an introduction outlining our current strategies and plans
- a summary of the national 2025-26 NHS Operational Planning priorities
- an outline of the wider national context and the focus of the emerging priorities of the NHS 10 Year Plan, including the three "national shifts"
- our guiding principles for prioritisation
- a summary of our key priorities, strategic programmes and system enablers.



2.4 As part of our 2024-29 Joint Forward Plan, we specifically focused on two areas ***Financial Sustainability*** and ***Urgent and Emergency Care***, we have identified two additional priority areas for 2025-26 ***Planned Care*** and ***Neighbourhood and Population Health*** these are supported by the 6 Strategic and Enabling programmes described in the table above.

2.5 The priorities broadly align with much of the headline priorities in the 10-year plan recognising there are areas we will need to refine and develop existing plans. This is outlined in more detail in the Chief Executive's Report earlier on the agenda.

- **From hospital to community**: Including more care closer to home, with Neighbourhood Health Services and a shift to digital alternatives and care planning.
- **From analogue to digital:** Including single patient records, use of AI, the Federated Data Platform to connect information across healthcare.

- **From treatment to prevention:** Including a focus on a smoke-free generation, tackling obesity, reduce alcohol harm, and eliminating cervical cancer, with a key focus on improving access and screening uptake through the Neighbourhood Health Service and scaling genomic and predictive analytics to support prevention.

2.6 The Annual Delivery Plan detail provided in Appendix 2 (Board Level measures) and Appendix 3 (Full plan measures) builds around these agreed programmes and is presented as a tracker document providing the framework to monitor progress against our priorities outlining our 'Must Do's, and includes detail on:

- Priority/programme areas and reporting routes.
- A summary of the key programme delivery areas
- A focus on the national NHS 'Must Do' priorities (Included in Appendix 2 as well as in the full plan in Appendix 3)
- Headline outcomes for each programme
- Agreed 2025/26 measures and where feasible defined metrics*
- Quarterly trajectories (where it is feasible to measure in year)
- In relation to the financial sustainability programme an identified Cash Releasing Efficiency Saving (CRES).

*Note - the metrics are fully aligned with the agreed activity plans and the refreshed Integrated Performance Report.

2.7 Further to the publication of information, and ongoing work, in relation to the revised NHS operating model, including the Model ICB Blueprint, and the material changes this will require of the Cheshire and Merseyside ICB operating model the contents of the plans will need to be revised as we transition to reflect these new arrangements through the remainder of the year and the move to ICBs being a strategic commissioner with some functions moving to other organisations.

2.8 In addition to the information contained in the appendices it is important to recognise there are wider clinical pathway developments that are managed through the wider system programmes led by our partners, including NHS England Clinical Networks and the NHS Provider Collaborative. This pathway redesign work contributes to the delivery of a number of our key priority areas and supports our financial sustainability plans but isn't described in detail within the associated tracker. This will need to be considered as we develop our responses to the 10-year plan and as the future NHS operating model is finalised alongside developing the ICB role as strategic commissioners.

2.9 The Cheshire and Merseyside System Financial Control Oversight Group (FCOG) overseas a programme of system wide transformation delivering efficiency and contributing to financial sustainability whilst this is included in the Annual Delivery Plan tracker there is further work ongoing to build on the work and plans developed to date, future iterations of the tracker will need to be refreshed this so that it remains current and valid.

2.10 All the headline national priorities ("must do") contained in the national planning requirements (see appendix 2) are included in the Integrated Performance Report with more detailed milestones and measures through our sub-committee governance.

2.11 Oversight of the priorities in the Annual Delivery Plan is currently mapped into the existing ICB governance arrangements, and this will be amended to reflect the Board agreement in relation to revision to these governance and Board committee arrangements.

3. Ask of the Board

3.1 The Board is asked to**:**

- **note** the attached programme content contained within the Annual Delivery Plan tracker shown in Appendix Three (the 'Must Do's' are summarised into Appendix Two).

- **note** an updated Joint Forward Plan will be produced later in 2025-26 to reflect the detailed plans required to implement to the final arrangements in relation to the new NHS operating model, including national ICB Blueprint, the10-year Plan ("Fit for the Future")[1] and Local Authority devolution arrangements.

4. Reasons for Recommendations

4.1 The Annual Delivery Plan priorities were developed following the nationally defined requirements identified in the NHS England planning guidance on developing Joint Forward Plans and to prioritise delivery of the national "must do" requirements of 2025-26 national priorities and operational planning guidance alongside key local priorities.

4.2 The Annual Delivery Plan tracker has been developed from discussions and insight from the ICB Executive Team, Programme Leads (including aligned NHS Clinical Networks), ICB/S Functional Leads, Place Partnerships, and alongside our system partners including the VCFSE sector, Providers and Provider Collaboratives. It is recognised we are in a transitional period and the plan will need to evolve to reflect national priorities of the 10 Year Plan and final arrangements in relation to the new NHS operating model.

5. Background

5.1 The JFP is a nationally mandated document which combines the Cheshire and Merseyside delivery plans to:

- improve the health and wellbeing of our population.
- improve the quality of services.
- make efficient and sustainable use of NHS resources.

5.2 Whilst the JFP covers a five-year period there is a statutory requirement to update and republish the plans each year, inevitably this annual update means the document focuses on the next 12 months and includes the key actions identified in our plans.

5.3 During 2024-25 a revised Health and Care Partnership Strategy was developed: ***All Together Fairer: Our Health Care Partnership Plan*** this was signed off in September 2024 as such the content still stands and provides detail on how we will work collectively as a system to address the social determinants of health and health inequalities.

5.4 The first Cheshire and Merseyside Joint Forward Plan (JFP) was approved by the ICB Board in June 2023 with a refresh in 2024. The NHS Delivery plan element of this was signed off by board in August 2024. A summary Annual Delivery Plan was also developed the intention was to produce an updated 25/26 version outlining our current priorities, anticipated outcomes, annual measures and defined metrics.

5.5 The plan also describes how we work as part of the wider system outlining how our core enabling strategies to enhance and support delivery.

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**

6.1 All of the above are core elements in the Joint Forward Plan, the light touch refresh and are included in the Annual Delivery Plan tracker contained in the appendices.

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

7.1 As outlined this paper focuses on the refresh and fully reflects the current Joint Forward Plan and the associated NHS Annual Delivery Plan – a refined NHS Cheshire and Merseyside Integrated Care Board Annual Delivery Plan will be developed in line with the proposed National ICB Blueprint, the recent 10-year Plan and Local Authority Devolution. It will also include enhanced programme governance and reporting processes to ensure a robust delivery approach.

8. Link to meeting CQC ICS Themes and Quality Statements

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

8.1 The key themes above are included in the Joint Forward Plan, NHS Delivery Plan and have been integrated into the associated NHS Cheshire and Merseyside Integrated Care Board Annual Delivery Plan tracker.

9. Risks

9.1 The NHS Annual Delivery Plan has been mapped to the Board Assurance Framework. In addition, there are a range of related additional risks that are being considered.

9.2 That current plans do not provide sufficient detail or stretch in their timelines to fully assess progress, or it may be that the reporting regime is not robust enough to provide the necessary stretch or challenge it is anticipated that the Annual Tracker will reduce the risk.

9.3 The programme management resources to support this ongoing development need is limited and will need to be enhanced to support and ensure delivery and an ongoing assessment of priorities and use of resources by the Executive Team and Board

9.4 Delivery of the requested reduction in the running cost allocation and alignment to the new NHS operating model and ICB Blueprint may well have a significant impact on the ICB's ability to deliver aspects of the Annual Delivery plan. This will become clearer as we begin to finalise the details of the revised national operating model.

10. Finance

10.1 Financial planning for 2025/26 is reflected in the JFP refresh, Annual Delivery Plan with a primary focus on financial sustainability.

11. Communication and Engagement

11.1 Much of the content of the JFP and subsequently the NHS Delivery Plan has been developed through existing programmes, which have established mechanisms for engagement in developing the plans. The nature of our Financial Sustainability Programme means there is an increased need for engagement, and where appropriate consultation, in line with statutory duties in relation to service change.

11.2 A copy of the Annual Delivery Plan tracker has been shared with stakeholders during Quarter 1 2025, feedback received has been incorporated into the final

version. The ICB Executive Team, including Place Directors, have also had sight during its development.

12. Equality, Diversity and Inclusion

12.1 Overarching Equality Impact Assessment (EIA) and Quality Impact Assessments have been completed for the Annual Delivery Plan, individual EIAs will be produced as required to assess the impact of the individual programmes and plans, including the financial sustainability programmes. The EIA can be found in Appendix 3, and the QIA is available on request.

12.2 A working group has reviewed and refreshed our Equality Impact Assessments (EIA), and Quality Impact Assessment (QIA) policies and processes to support effective delivery of the changes that will be delivered through our priorities and specifically the financial sustainability programme.

13. Climate Change / Sustainability

13.1 Climate change and sustainability are included as priorities in the ***All Together Fairer: Our Health and Care Partnership Plan*** and associated HCP delivery plan and as one of our headline ambitions.

14. Next Steps and Responsible Person to take forward

14.1 The ICB Strategy and Collaboration Team working with the Planning and Performance Team and Executive Team will:

- Develop a revised Joint Forward Plan to ensure our plans are fully responsive to the priorities and opportunities outlined in the NHS 10 Year Plan and aligned to the NHS operating model and ICB Blueprint and our development plans to enhance our capability as strategic commissioners.
- Review the monitoring and oversight of the plan to ensure aligned with changes to the ICB Governance arrangements in the summer of 2025.

15. Officer contact details for more information

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Stephen Woods
Head of Strategy
stephen.woods@cheshireandmerseyside.nhs.net

16. Appendices

Appendix One: (CLICK HERE) Joint Forward Plan 2025-26

Appendix Two: Annual Delivery Plan Tracker (Board Level reporting)

Appendix Three: Annual Delivery Plan Tracker (Full plan) **(CLICK HERE)**

Appendix Four: Equality Impact Assessment (EIA) **(CLICK HERE)**

2025 / 26 Annual Delivery Plan Tracker - ' Must Do's' - Board Level reporting
(Note these reflect the national planning guidance and are included in the Integrated Performance Report)

* Priority 1 - Financial Sustainability

Reporting route pending the review of committee structure	Key Programme areas (reporting routes)	Key Outcome	25/26 measure/s * GREEN - indicates board level reporting BLUE indicates reported in the Integrated Performance Report (IPR)	Metric	Quarterly Trajectories				Total Savings £m's
					Q1	Q2	Q3	Q4	
Financial sustainability (Financial Control Oversight Group (FCOG) to Finance Investment and Resources Committee (FIRC)	Deliver a balanced net system budgeted financial position	We will operate within our financial allocation recurrently	* Deliver a balanced net system financial position (25/26) IPR	Planned surplus/-deficit figures position at Q1 was -£51.7m so a favourable variance to plan of £1.4m.	-£53.1m	-£29.1m	-£4.7m	£86.9m	
				CRES the planned system savings by quarter - position at Q1 was £97.7m so a favourable variance to plan of £0.6m.	£97.1m	£126.8m	£151.6m	£197m	TOTAL £572.5M
				ICS capital (covers providers and the ICB).	£65.7m	£61.3m	£61.3m	£61.3m	£249.5m

* Priority 2 - Urgent Care Improvement

Reporting route pending the review of committee structure	Key Programme areas	Key Outcome	25/26 measure/s * GREEN - indicates board level reporting BLUE indicates reported in the Integrated Performance Report (IPR)	Metric	Quarterly Trajectories				Notes
					Q1	Q2	Q3	Q4	
UEC Board to	F13 - UEC at scale (Cross reference with	We will eliminate corridor care in our hospitals	* 4 Hour A&E waiting times (Min78% March 2026) IPR	National 78% local trajectory 78.2% Latest ICB Performance (Mar-25) = 72.6%	73.5%	75%	76.50%	78.2%	As per planning submission

Q&P Committee	Neighbourhood Health Programme)								
	In Hospital flow		* 12-hour breaches improve across 2025/26 compared to 2024/25 IPR	Latest ICB Performance (Mar-25) = 16.2% North West 13.2% and England 9.7%.	16.4%	16.3%	16.5%	15.6%	Takes account of Winter in Q3
	Ambulance improvement with a focus on response times and handover		* Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26 IPR	30 minutes Latest ICB Performance (Mar-25) = 00:32:43	00:30:00	00:30:00	00:30:00	00:30:00	Plans reset as of April 25
			*Mean ambulance handover time IPR	National 15 minutes Local target Mar 26 = 00:28:20 Mar 25 actual = 00:34:32 (plans reset from April)	00:38:11	00:35:56	00:33:46	00:28:20	Plans reset as of April 25

* Priority 3 - Planned Care									
Reporting route pending the review of committee structure	**Key Programme areas**	**Key Outcome**	**25/26 measure/s * GREEN - indicates board level reporting BLUE indicates reported in the Integrated Performance Report (IPR)**	**Metric**	**Quarterly Trajectories**				**Notes**
					Q1	**Q2**	**Q3**	**Q4**	
C&M Provider Collaborative to Q&P Committee C&M Cancer Alliance to Q&P Committee	F11 - Planned Care Elective Recovery Programme and Diagnostics	Meet the 18-week referral to treatment standard by March 2029 Meet the Cancer treatment and early diagnosis targets	* Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement IPR	National 60% local target 62.9% - Mar 25 = 58.0%	58.20%	59.60%	61%	62.90%	As per planning submission
			* Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to	National 72% local target 67.2%	63.40%	64.70%	66%	67.2%	

			deliver a minimum 5%-point improvement OPS plan Key						
			* Reduce the proportion of people waiting over 52 wks. for treatment to less than 1% of the total waiting list by March 2026 **IPR**	National/local target 1% Mar 25 = 3%	3%	2.50%	1.80%	1%	Plans reset as of April 25
	Cancer Treatment and early diagnosis		* Improve performance against the headline 62-day cancer standard to 75% by March 2026 **IPR**	National 75% by March 2026 local trajectory 75% Latest ICB Performance (Mar-25) 76.4%	73.20%	73.90%	74.70%	75.0%	Plans reset as of April 25

*** Priority 4 - Neighbourhood and Population Health (Inc. Mental Health Learning Disability and Autism, Children and Young People (Beyond), Women's Health and Maternity (WHaM))**									
Reporting route pending the review of committee structure	**Key Programme areas**	**Key Outcome**	**25/26 measure/s * GREEN - indicates board level reporting BLUE indicates reported in the Integrated Performance Report (IPR)**	**Metric**	**Quarterly Trajectories**			**Notes**	
					Q1	**Q2**	**Q3**	**Q4**	
Primary Care Committee	Modern General Practice and Primary care	Patients to access appointments in a timely way and improve patient experience. (ICB submission of Plan to NHS England by end of June 25)	* Improve patient experience of access to GP as measured by the ONS Health Insights Survey GP Patient Survey (GPPS) (other patient experience measures will be used) **Agreed Key deliverable Planning Guidance**	% patients describing their overall experience of their GP practice as 'very good' or 'good' (GPPS) % patients describing their overall experience of contacting their GP practice as 'very good' or 'good' (GPPS)	GP dashboard goes live anticipated Q1 / Q2 Action Plan agreed Q2 / Q3 Measures and metrics to be confirmed and reported through Primary Care Committee				

			*Appointments in General Practice & Primary Care networks (NEW) **IPR**	Trajectory established as per planning submission position Apr 25 =1,237,568	1198474	1266474	1203796	1404738	As per planning submission
	Urgent Dental	Increase the number of urgent dental appts in line with the national ambition to provide 700,000 more	*Number of Appointments expected to be delivered in each month as a result of additional commissioning activities **IPR/Planning guidance IPR**	Total for April 25 - March 26 = 46617 (3885 per month)	11652	23307	34,962	46617	As per planning submission
				Number of unique patients seen by an NHS Dentist – Adults (24 month) Number of unique patients seen by an NHS Dentist – Children (12 month)	940075 334258	943484 334384	946893 342511	950302 346638	As per planning submission
Mental Health Forum DTCIAB Suicide - HCP (NO MORE Suicide Partnership) LDA Q&P Committee	Delivery of the Children and Young People Mental Health Transformation Programme	The plan delivers a unified, collaborative, and strategically aligned approach to children and young people's mental health, ensuring services are responsive, fair, and focused on reducing health inequalities	* Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0-25 compared to 2019 **IPR**	The CYP Mental Health (MH) Access target for Cheshire and Merseyside is 37,590.	9397	18795	28192	37,590	
	Maternity and Neonatal Services - Improve safety in maternity and neonatal services, delivering the key actions of three-year delivery plan	Continue to improve safety in maternity and neonatal services, through delivery of key actions of the three-year delivery plan	*Still birth rate reduction / below peer rate? NEW **IPR**	Still birth per 1,000 (rolling 12 months) National value 3.8 locally 2.95 Mar 25)					

Population Health Board	Healthy Behaviours: Reported via CVD Prevention Board > Population Health Board	We will reduce the gap in healthy life expectancy between our least and most deprived wards alongside increasing the overall average Healthy Life Expectancy for our population. {insert date}	*Smoking at Time of Delivery (NEW) **IPR**	<6% Latest Performance (Q3-24/25) = 6.1%	6.10%	5.90%	5.80%	5.70%	Plans reset as of April 25
			* Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025 **IPR**	80% Latest ICB Performance (Q2-24/25) = 65.6% Latest National position = 66.8% *70% ambition in 25/26; current performance too far from 80% target ambition	66	67	68	70	Plans reset as of April 25
			* Increase the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance **IPR**	% ambition still awaited from central team Latest ICB Performance (Q2-24/25) = 44% Latest National position = 46%	TBC - % ambition still awaited from central team				

* System Enablers - (Improving Quality Safety and Experience - Digital and Data - Workforce)									
Reporting route pending the review of committee structure	**Key Programme areas**	**Key Outcome**	**25/26 measure/s * GREEN - indicates board level reporting BLUE indicates reported in the Integrated Performance Report (IPR)**	**Metric**	**Quarterly Trajectories**				**Notes**
					Q1	**Q2**	**Q3**	**Q4**	
Q&P Committee	Infection Prevention control	Reduced rate of infections preventing harm and reducing burden on services	*Healthcare Associated Infections: Clostridium Difficile - All Cases Healthcare Onset Healthcare Associated (HOHA), Community Onset Healthcare Associated, (COHA) Community Onset Indeterminate Association (COIA) Community Onset Community Associated (COCA) IPR	System tolerance of 900 cases Mar 25 Baseline 1191	1191	1102	1001	900	Plans reset as of April 25
			*Healthcare associated infections: E coli (All Cases) IPR	System tolerance of 2124 cases Mar 25 Baseline 2330	2330	2265	2195	2124	Plans reset as of April 25
	See Maternity section in the previous section		*Still birth rate reduction / below peer rate? NEW IPR	Still birth per 1,000 (rolling 12 months) National value 3.8 locally 2.95 Mar 25)					
People Board	Systemwide Operational Workforce Planning / Efficiencies at Scale	Systemwide Operational Workforce Planning - the ICB and ICS Health & Care Providers will operate within our financial allocation re-currently.	*Achieve planned reduction in current workforce WTEs - from a total Trust workforce baseline of 80,531 WTEs to 77,497 WTE (-3.8%) particular focus on temporary staffing utilisation (Bank & Agency) and workforce pay bill / spend in line with Provider / System Financial Plan for 2025/26. With a reduction in Bank WTEs by 16.6% and Agency WTEs by -35% IPR	Variance year to date - workforce plan NHS Trusts & General Practice Level of confidence in delivery of workforce plan (WTEs)	79942	79365	78359	77487	
				Variance year to date workforce plan general practice - Total GP's	1907	_	_	1907	
	Staff Experience, Health & Wellbeing	Improved performance across NHS cultural metrics, supporting a thriving workforce which	*Health & Well-Being and Staff survey results, improved workforce retention & reduced staff turnover rates, student & trainee survey results for registered	Number of GPs to leave in the last 12 Months					
				Sickness Absence Rate (NHS Trusts)	6.40%	6.20%	6%	5.80%	

		have the greatest impacts on patient outcomes	medical / clinical professions – **IPR (with exception of GP numbers)**	Turnover Rate (NHS Trusts)	11.60 %	11.40 %	11.50 %	11.30 %	

*** Priority - All Together Fairer**									
Priority /Programme area and reporting route	**Key Programme areas**	**Key Outcome**	**25/26 measure/s * GREEN - indicates board level reporting BLUE indicates Integrated Performance Report (IPR)**	**Metric**	**Quarterly Trajectories**				**Notes**
					Q1	**Q2**	**Q3**	**Q4**	
All Together Fairer All Together Fairer Board (HCP) Sustainability Board Health Care Partnership	Social determinants: Tackling Poverty Serious Violence Duty Housing and Health Work and Health	We will collaborate with wider partners within the Health and Care Partnership to contribute to reducing the gap in life expectancy between our most and least deprived communities	*Gap in female life expectancy between the most and least deprived and Gap in male life expectancy between the most and least deprived We will commit to improving the outcomes across the three leading causes of the gap in life expectancy between the most and least deprived communities in Cheshire and Merseyside which are Cancer, Circulatory Disease and Respiratory Disease by: **IPR – includes respiratory as it is a key Population Health challenge in C&M**	Increasing the proportion of cancers being diagnosed at stage 1 and 2 – planned care target	See planned care targets				
				Achieving the two CVD prevention targets - neighbourhood and population health targets	See targets in Neighbourhood and Population Health				
				Reduce respiratory related emergency hospital admissions by 5% based on 24/25 figures	QI 5365	Q2 4425	Q3 7692	Q4 6232	24/25 position
					QI 5097	Q2 4204	Q3 7307	Q4 5920	5% target reduction

NHS
Cheshire and Merseyside

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

Held at the Authority Chamber, No1 Mann Island, Liverpool, L3 1BP

Thursday 29th May 2025
9am-12.30pm

Unconfirmed Minutes

ATTENDANCE	
Name	**Role**
Members	
Raj Jain	Chair, Cheshire & Merseyside ICB (voting member)
Graham Urwin	Chief Executive, Cheshire & Merseyside ICB (voting member)
Erica Morris	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Dr Ruth Hussey, CB, OBE, DL	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Prof. Hilary Garratt	Non-Executive member, Cheshire & Merseyside ICB (voting member)
Mark Bakewell	Executive Director of Finance (Interim), Cheshire & Merseyside ICB (voting member)
Christine Douglas, MBE	Executive Director of Nursing and Care, Cheshire & Merseyside ICB (voting member)
Prof. Rowan Pritchard Jones	Medical Director, Cheshire & Merseyside ICB (voting member)
Adam Irvine	Partner Member (Primary Care) (voting member)
Andrew Lewis	Partner Member (Local Authority) (voting member)
Prof. Stephen Broomhead	Partner Member (Local Authority) (voting member)
Ann Marr	Partner Member (NHS Trust) (voting member)
Dr Naomi Rankin	Partner Member (Primary Care) (voting member)
Trish Bennett	Partner Member (NHS Trust) (voting member)
In Attendance	
Clare Watson	Assistant Chief Executive, Cheshire & Merseyside ICB (regular participant)
Anthony Middleton	Director of Performance and Planning, Cheshire & Merseyside ICB (regular participant)
Dr Fiona Lemmens	Deputy Medical Director, Cheshire & Merseyside ICB (regular participant)
John Llewellyn	Chief Digital Information Officer, Cheshire & Merseyside ICB (regular participant)
Mike Gibney	Chief People Officer, Cheshire & Merseyside ICB (regular participant)
Sarah Thwaites	Healthwatch
Laura Marsh	Interim Cheshire West Place Director, Cheshire & Merseyside ICB
Prof. Paul Kingston	Lead Chair of Research Committee, University of Chester
Louise Robson	Chair, Health Innovation North West Coast (regular participant)
Mandy Nagra	Chief System Improvement and Delivery Officer, Leading system recovery, Cheshire & Merseyside ICB
Rev. Dr Ellen Loudon	Director of Social Justice & Canon Chancellor of Liverpool Cathedral, Vice Chair C&M Health and Care Partnership
Jamaila Hussain	Interim St Helens Place Director, Cheshire & Merseyside ICB
Sally Thorpe	Executive Assistant - Board Administrator, Cheshire & Merseyside ICB

Apologies	
Name	**Role**
Prof. Ian Ashworth	Director of Population Health, Cheshire & Merseyside ICB (regular participant)
Mike Burrows	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Tony Foy	Non-Executive Member, Cheshire & Merseyside ICB (voting member)

Agenda Item, Discussion, Outcomes and Action Points

Preliminary Business

ICB/05/25/01 Welcome, Introductions and Apologies

All those present were welcomed to the meeting and advised that this was a meeting held in public. The meeting was declared quorate. Apologies for absence were noted as above.

ICB/05/25/02 Declarations of Interest

There were no declarations of interest in relation to the agenda.

ICB/05/25/03 Chairs announcements

Given recent events in the Liverpool City Region it was formally acknowledged an immense thank you to all in the NHS and the emergency services for their responses to the incident and to extend support to those injured and/ or affected.

The Board were advised that this was the last meeting for Graham Urwin as Chief Executive and thanks were conveyed for his leadership and contributions.

Additionally, it was advised that this was also the last meeting for Prof. Steven Broomhead who has announced his retirement in Summer, thanks were conveyed for his support and for the challenges and contributions to the agendas and subsequent discussions.

ICB/05/25/04 Experience and achievement story

A short video was shared in relation to the All Together Fairer Plan and the scale of poverty for children in Cheshire and Merseyside.

Leadership Reports

ICB/05/25/05 Report of the ICB Chief Executive

Changes to the ICBs Operational Scheme of Reservation and Delegation
Firstly, it was stated that there was a specific recommendation within the report around the ICB scheme of delegation, and it was asked, with the permission of the Chair, to withdraw this item today. It was advised that representation had been made since the publication of the report suggesting there needs more debate than can be given justice within the Board meeting today.

Secondly, thanks were offered to the team for putting the report together, and notwithstanding the statement that this was the last meeting in the position of Chief Executive there are a number of successes highlighted since the inception of the ICB.

Financial regime
The Chief Executive outlined that Cheshire and Merseyside ICB is one of the last two ICBs in the country to agree a financial plan with NHS England (NHSE)this year, and that the plan includes £178m of deficit support funding. If this plan goes ahead this means the ICB will be spending 2% more than its legitimate allocated resources from NHSE.

There are concerns and risks associated with this, some risks we would self-declare and being cognisant and mindful of this, the Board have appointed Mandy Nagra to tackle some of the financial and system turnaround issues, but also to gain confidence on this.

Additionally, NHSE have asked that we accept a piece of diagnostic work by Price Waterhouse Cooper (PWC) that will take place over the next two-three weeks against the delivery of the 2025/26 plans.

We have two further challenges; one is the here and now and the deficits that exist within the providers of care within the system, and the second issue, one that the Board are sighted on, around the longer-term plan. This is not only about the ICB receiving deficit support above our allocation this year, but that NHSE have indicated their desire to accelerate a movement towards a fair share use of funding in the country. This historically has been based on a public identifiable formula, but since covid this had been paused.

All indications are that NHSE will use their powers to speed up and move back to fair share, therefore we would have to accept that we are effectively over commissioning healthcare and that we will need to look to draw back to our growth and fair share. The more quickly we get back to fair shares the better we can make the three shifts; invest in care outside of hospital; how we invest in the digital agenda and how we invest in a more proactive and less reactive care provision.

Additionally, the Board were made aware, over the next quarter, the need to bring forward a three-year financial strategy for the ICB.

Model ICB Blueprint
The Chief Executive updated the Board that following the recent Prime Minister announcement effectively abolishing NHSE and most of the functions of NHSE being transferred back into the direct control of the DoH, it was confirmed that in terms of the architecture of the ICBs, they were here to stay, however their role would be redefined. Additionally, through that process and in line with the PM's announcement, ICBs would need to cut their running costs by 50% for the average ICB. Cheshire and Merseyside ICB is larger in size and scale and this brings certain economies, therefore in terms of management and running costs our cuts required will be closer to 30%. Over the next few months it was advised that the functions will be redefined and there will be a significant staff engagement process that will lead to a number of redundancies for our directly employed workforce.

All other items were taken as read within the Chief Executive Report.

Board comments:
In support of the terrible incident during the Liverpool FC Victory Parade, the message was reinforced for the emergency services, for their brave, speedy and subsequent care given, not only to Liverpool but across the region.

In terms of the change in leadership, thanks were extended for the strong partnerships that have been forged within the nine local authorities and within the NHS partnerships in this region.

In terms of the huge pressure on NHS costs, it was acknowledged that looking forward there will be a strong emphasis on fair shares, and it was asked that for the Board and for those who need support of the political leadership of region, whether a factual note or briefing could be shared so that the concept and formula of fair share can be fully understand.

In response to this, it was agreed that, in time, the Director of Finance would provide such a briefing.

Action: Mark Bakewell to develop and circulate to Board members a short factual note/briefing regarding NHS funding and fair shares funding and the formula behind it

It was further highlighted that there are now good relationships built up in the region, and a plea given to continue to build on these. In relation to the ICB blueprint it was stated that these were developed by the staff but without any real engagement or consultation at local level. It was asked that the transition committee, when established, has proper engagement and consultation with local government and partners.

Working with local authorities and partners is noted to be part of our core business, and that it reaches all parts of our business, it was confirmed that there is both Board and staff commitment to work with system partners to work together to the future, the model ICB will form the basis of the work going forward and the key message is to do this together.

Noted that it is an absolute requirement by the government regarding the increasing consumption of resources in the NHS, and the speed that this is being done at means it is not as specific as it perhaps could have been, however it does mean we can design and work with the plan. It is recognised that the 10-year plan is due for announcement in June.

The Board:

- **considered the updates and noted the contents of the Chief Executive Report**
- **agreed with the withdrawal of the item marked 'to approve' in relation to the ICBs Operational Scheme of Reservation and Delegation**

ICB/05/25/06 NHS C&M Finance Report Month 12

Month 12 report shows the position of the ICB and all the NHS trusts within our system. The assets show a pre-audit benefit of £201.3m for the financial year, which includes a £25.4m surplus from the ICB and a £76.7m deficit from providers. The system had previously received £150m in revenue deficit support from NHSE, which is repayable from 2026/27.

This is tracked through the year and was an adverse move from M11 to around £5.5m which was agreed in advance.

It was outlined that there was more information detailed within the papers, including drivers for the positions at both commissioner and provider side. There are measures of workforce, banking, agency expenditure and it is increasingly obvious where the focus needs to be in terms of efficiency and productivity within the system.

The Board were made aware that the reported financial condition still remains subject to the ongoing audit process which is hoped to be concluded over the coming weeks.

The Board;

- **noted the final reported financial position and metrics for 2024/25, which are now subject to audit processes**

ICB/05/25/07 Highlight report of the Chair of ICB Finance, Investment and Our Resources Committee

It was noted that on weekly basis there is a Financial control and oversight meeting where all senior responsible officers (SROs) and Finance colleagues work through their plans, there is also a monthly system leadership and all this detail is included in the ICB Finance and Investment Committee, there is basic detailed analysis of the risk performance on what remedial actions are being put in place, then it goes to escalation potentially in the form of Board to Board or NHSE colleagues. We also have to acknowledge that we have had involvement from PWC with our providers and ourselves to get to this point.

Additionally, it is important to acknowledge the fantastic positive engagement from across the system, and this is a credit to the providers in these difficult times.

The Board noted the report

ICB/05/25/08 NHS C&M Integrated Performance Report

The report was noted to cross the transition of the old financial year and operating requirements and into this new year. There are some new standards and new indicators, but because of the transition the report also includes exceptions of variation across the year

Latest position of urgent care standards, April flags as green within the report but the plans for this year have been somewhat reset and trajectory with it, although there is some improvement for April for the non-criteria to reside in April was the best we have seen some time.

In terms of planned care, we maintain our position in the diagnostic performance as the first and highest performing ICB in the country and against the 18-week standard we achieved our year trajectory. There is challenge ahead through pathway redesign and this will be done hand in hand with our patients and system.

In relation to the question raised relating to planned care performance issues, there was reflection regarding the gynaecology situation, where nationally this had been an issue in terms of inequality, and it was noted that this did not feature as an action on the report, it was questioned therefore where the progress for women in Cheshire and Merseyside. It was advised that this was primarily led by the provider collaborative and that there will be a full update in due course. It was advised that for example, the ambulatory unit at the Women's Hospital is due to go live in July, and there are elements in terms of genuine pathway redesign where improvements are being seen and this fairs well in comparison with England.

It was noted that the number of referrals has increased significantly and most of them are around menopause type issues. Capacity has been increased at Liverpool Womens but also looking at pathways so as to not get as many referrals coming through to provide advice and guidance for other pathways and to reduce and manage demand. Group consultations are also being tried out to give advice and support collectively. Lots of work being done on stemming flow by having things in community, as well as diagnostic programme to get into a better place than have been so far.

Noted that in relation to gynae waits one piece of work that has commenced is the building on the work with CMAST is bringing the learning from Birmingham Womens for example and embed the opportunities.

In terms of Women Health, we are ahead of most places in the country, but we do recognise it is challenging and we do need to do more. We are working with our local authority colleagues to do joint commissioning and who pays for what, this is a fundamental shift of resources. Everything so far has been secondary care based and now we have to shift that resource into primary care and there is a huge appetite for this.

Noted caution when talking about womens health hubs particularly at the national strategy as there a specific target that those health hubs should cover, for example in Liverpool, the hubs established are specifically for LARC (long acting reversable contraception) which is funded by local authority and is funded through PCNs and the GP practices. These clinics have shown significant cost savings across primary care and within the wider system. There have also been a number of pilots recently where PCNs work alongside Liverpool Womens Hospital in order to train GPs in menopause and this has seen a significant cost saving, however the pilot has now ceased, so whilst the pilots have been successful, there is no continuation of those services. Without that funding and the collaboration between primary care and secondary care to work together to provide these services, it was asked of the Exec team and the commissioners to look at, and how to collaborate to be able to, continue these services.

In relation to continuing with innovations, it was reported that there is some discretionary funding for some services, and it is how we evaluate going from a pilot to a mainstream service, this highlighted

issue is a key example, and we need to build on these and have a more systematic approach and to build into our strategy and plans going forwards. The Board agreed that we should look to build on pilots and then move to a more systematic approach to evaluation in due course.

Page 116 (26 of the perf report) was highlighted, and not being complacent, but recognising that dental access is still an issue, the primary care dental team and the dental contractors, the detail shows we scored 38 out of the 42 ICBs in our performance around dental access for adults, but at the end of the year we had improved to second out of the 42, there is a need to continue this, but did want to recognise the good work and the investment being made in our dental improvement plan.

It was noted that the System Primary Care Committee (SPCC) sees discussion around the increase in GP appointments and that wealthier areas get more access compared to the more deprived areas and the Chair asked if the Board would think about how that data is feedback and reported to Board. It was advised that there was a new national dashboard / scorecard around access and will support the June plan that is going in around variation of GP access. It was suggested that the Board in July could see this following its submission to SPCC.

ACTION: Clare Watson to bring back a report to Board in July on GP appointments and access following submission to SPCC in June incorporating new national dashboard data

The Board noted the contents of the report and take assurance on the actions considered

ICB/05/25/09 Highlight report of the Chair of ICB Quality and Performance Committee
- **Including update of Safety report development**

In the absence of the Committee Chair, it was taken that the paper was read and noted. No questions were raised.

ICB/05/25/10 Highlight report of the Chair of ICB Audit Committee

In the absence of the Committee Chair, it was taken that the paper was read and noted. No questions were raised.

ICB/05/25/11 Highlight report of the Chair of System Primary Care Committee

Thanks were given to the nine Healthwatch's, in relation to this piece of work that was commissioned to look at how it feels to get GP access. This was subsequently reported back to SPCC to look at the measures put in for PCARP, the full report will come to July Board as to the plan and way forward.

Healthwatch stated that it did match what they see day by day, and what they hear from people how it is to get an appointment, the experiences can feel very differently to different people depending on their circumstances.

Missed agenda item: Verbal highlight report of the Chair of the Northwest Specialist Commissioning Committee

Outlined that this meeting where it covers the services that are commissioned between the three ICBs in the Northwest, there is a triple A report that will be circulated after Board.

Three issues were highlighted to Board following the last meeting in April;

- it has previously been agreed that some of the specialised commissioning staff to support this function would transfer to Lancashire and Cumbria ICB in July. However, the transfers are now on pause because of all the changes to the ICB functions (as previously mentioned)
- a procurement for adult critical care transfer service which was reported in April, there will be a further update at the next committee meeting, however at this time it is believed there are no bidders so will be looking at arrangements and consider the way forward at the meeting next week
- advised of a national research programme in the specialised commissioning sphere where the costs of the treatment in the research funders, but that the expectation was that the NHS would pick up

the excess treatment cost. This is being looking into and what our ICB policy would be and how this would affect our financial considerations.

Action: Specialised Commissioning Financial Oversight Claire to follow up with the Spec Comm leadership team to identify actions to reduce overconsumption of resources of SpecComm, with a report back to Board in three to six months.

ICB/05/25/12 Highlight report of the Chair of ICB Women's Hospital Services in Liverpool Committee

Outlined that the reports that were handed over at the last Board meeting, unfortunately came in after the closing date, we had extended the closing date for submissions for the engagement piece but it came in just afterwards so could not be formally included in the report, however for reassurance the programme board have absolutely used it in planning the next stage of what will be a very different process.

ICB Business Items

ICB/05/25/13 Proposal regarding ICB funded Gluten Free Prescribing across Cheshire and Merseyside

For the record, the Medical Director reported that he had coeliacs disease, having had the diagnosis at a very early age, he explained further that of his immediate family members, no less than four also have a diagnosis of coeliacs disease, and whilst (he) is one of the very few (less than 2%) who subsequently go on to eat normally his household have a very lived experience in managing diets within the household and beyond.

It was outlined that in Cheshire and Merseyside, we care for just of 13k patients with coeliacs disease and of these, there are approximately 2300 are prescribed bread and bread mixes. Guidelines are somewhat outdated (8 years or so) and not-surprisingly 99% of those patients are exempt from prescription charges.

There is already an unwarranted variation in that St Helens and Cheshire West withdrew from gluten free prescribing a number of years ago and this has been relevant to try to answer some of the questions that come forward to consultation.

Currently our spend is just over £0.5m on gluten free prescribing. The clinical working group have agreed with the concept of the prescribing level.

40% of ICBs have stepped away from prescribing gluten free products, two of them are our immediate ICB neighbours. The Board will remember the request to go into public consultation on this, and the paper now seeks, following that consultation, to move to a decision.

It was outlined that consideration had been given to an option to do nothing, but this has never been the stance and the ICB have always thought to move away from unwarranted variation across Cheshire and Merseyside. Another option is to prescribe everywhere, which undoubtably will bring a cost pressure, alternatively the option is to stop our gluten free prescribing altogether, which would allow the monies currently invested in this towards another area of health spend.

It was further outlined that as part of the consultation, there were some alternatives that initially pre-consultation had been dismissed; and this would be to prescribe to under 18's only (which would give a cost pressure of about 10% of our current investment), or we could prescribe to under 18s and vulnerable adults which would materialise a cost pressure of about 20%.

The consultation had a response of over 1000 responses, of which 77% were coeliac who reflected the lived experiences of gluten free foods being more expensive.

On the other side of this, is that the money that is currently spent could be better spent elsewhere in health, additionally we do not prescribe for other healthcare conditions such as lactose intolerant or diabetes. It was highlighted that access to gluten free products via most supermarkets is much better now than it has ever been, however it does remain more expensive than gluten counterparts, yet gluten free pasta is almost the same cost as regular pasta.

Additionally highlighted was that as a result of the consultation, the options to consider prescribing for those under 18, or under 18 and living in deprivation was something for the Board to be aware of as part of this decision. Attendance at joint Overview and Scrutiny committees has also taken place, and this has been helpful and had very detailed engagement. It was reported that they had sought to answer the questions of;

- did we know the impact of withdrawing prescribing gluten free bread and indeed in the areas where this has already been done in the two places, we have not seen any admissions associated with coeliac or osteoporosis
- the locations of the food banks which are good at stocking gluten free products, and how many coeliacs are accessing this through food banks

It is important to note that the promotion of diet options, food fairness and awareness of campaigns such as coeliacs disease is important and that we are mindful of these into the future.

The Executive Committee, which had been supported by various parts of the ICB, including our Clinical Effectiveness group agree to the consideration of aligning ourselves with other parts of the country in terms of not prescribing gluten free products.

There is a discrepancy between coeliac and other intolerances (lactose for example) and is similar in that they have products available but that currently we are making an exception to one and not others in terms of consistency. If we continue where we are now, we probably should look to treating the other disease groups the same and not giving preferential treatment.

There was general feeling from Board members that where possible all groups should be treated the same where possible and not to have some groups given preferential treatment over others.

Healthwatch added their support in that they supported the Board if the decision was to continue it for children (under 18's) noting that it can be very difficult to get a child to comply with eating a meal if it looks significantly different from everybody else's. Additionally noting that for a parent to provide a child with gluten free options for some families would struggle in terms of cost.

It was noted that there may have been an issue in the process of scrutiny and that it is particularly important that there is a statutory process to the decisions. It was noted that the ICB are very diligent in approaching each of the OSC panels, and it was recognised that there are some lessons to be learned in terms of how the scrutiny process runs when quoracy, or lack of quoracy stops a meeting taking place, or decision is not able to be met. It was requested that a member of the ICB liaise with the Knowsley scrutiny panel just to finalise the process. It was very much welcomed regarding the quality impact assessment, the social aspect and the protected characteristics considerations, this is critical as this is as much about poverty as well as it is health.

There was some disappointment expressed regarding some of the mitigations on the impact assessment and that it was important to recognise the public health response, it was suggested whether any of the savings could be put towards a process to support families with various intolerance following this decision.

In relation to the voluntary sector, it was recognised that food banks play a huge part. Liverpool City Region have just enabled some research, and Ellen Louden will take this back to look at the generalised package offered, usually through the Trussell Trust, the way that food banks can be

accessed, and feel that we need to be careful not lean into this becoming a statutory provision, food banks are used in emergencies, and food pantries are the everyday help locations.

Important for the Board to remember that two of the Cheshire and Merseyside Places have already done this and we have significant deprivation in those locations, families have found their way and adapted, it is important that we learn from what we've already successfully done.

One key priority for the HCP is around Children and poverty, it was noted regarding all the comments made today, but it was requested to be mindful of this priority when making the decision.

DOI – Raj Jain stated that he was Chair and champion of the CYP and was very much focussed against children living in poverty.

It was suggested that there will be a number of similar initiatives and perhaps we should collectively be looking to package some of these things together and not do 'piecemeal' so as to get a consistent approach. There will be a number of system changes and we need to get the relationship right between ICB and OSC so as to not have to go nine times.

Welcome the approach to food poverty through different programmes, in making this decision we will be withdrawing from families, and we need to be mindful to manage this, it was suggested as an interim to continue this for under 18's and manage the immediate risk of the asset being withdrawn whilst we move to future decision.

Overall in principle, option 3 could be worked however there was concern expressed around the issue of food poverty and the other segments of our population, particularly the elderly and children and young people, it feels uncomfortable that there is no way to mitigate against this but to lean towards option 3 and be really clear of the impact.

Noted that by not acting in precedence this would potentially create a second unwarranted variation if we do not do this for the over 65s, but it would align with the children and poverty aspect. Would look to take up the advice and learning of Cheshire West and St Helens, and linking in with the working group which picks up the non-reliance of provision and access and look to share this with other places.

The Board;

- **noted the work undertaken to date, the Public Consultation Feedback and the efforts made to achieve its duty and obligations to formally consult with Local Authority Health Oversight and Scrutiny committees**
- **considered the additional options provided following a period of conscientious consideration to reflect the Public Consultation Feedback and re-visit EIA**
- **took account of the Executive committee's preferred option to proceed with the original proposal to cease all prescribing of Gluten Free Bread and bread mixes**
- **noted the risks and mitigations as described within the Options, QIA and EIA documentation**
- **confirmed to make a decision on a single option, to determine the Policy position for NHS Cheshire and Merseyside, so that a harmonised policy position can be implemented**

Decision: Option 3, cease NHS funded gluten free prescribing, however in the existing Places where under 18s are receiving prescriptions for GF foods, to continue for a further 6 months to and within this time work with the Directors of Public Health to understand what our strategy and plans should be around food poverty and in particular focussing on access to gluten free food within this time period.

ICB/05/25/14 Post COVID Syndrome Review and Options Development

Dr Fiona Lemmens outline to the Committee that the ICB has been reviewing the long covid service over the last six months or so, the Board will be aware that the current multiple hub service has now

stopped, now looking at all options available to make sure we provide for the needs of the ongoing population of patients who are suffering from the impact of long COVID.

Thanks were given to the commissioning team who have done a lot of engagement with members of the public, national groups and local people with lived experience, and who have conducted a very thorough review of the evidence available to us to help us make our decisions.

This has led to seven options for consideration for future services, these have been taken through the clinical effectiveness group and then to the Executive Committee. From this, and the information shared the options have then further reduced the number of viable options to three and these are as given in the report.

Stakeholder groups have seen the three options and there have been very in-depth discussions and we have been really impressed with the level of knowledge and with national colleagues who have done a lot of work and campaigning on this issue. There have been some really well explained lived experiences from public and patients and this has really helped.

It is acknowledged that if we do not have some sort of provision or support to these patients, whilst there will be financial savings however in reality there will be quite a lot of hidden costs associated with this, as patients will still access other services that are not fully commissioned, and this will be felt in increased number of appointments in Primary Care.

The recommendation is to look to harmonisation, as this will allow us to address this issue as well. Therefore the ask of Board is to note the engagement and research process that has been undertaken to date to get to this shortlist of three, and what the Executive Committee have recommended is that we go away and do some more work on those options. The ask of Board is to endorse that recommendation of the Executive Committee. We can then work with the potential providers to ensure what is developed is a service that meets the needs that the stakeholders are telling us they need, but is the most cost effective.

It was stated that GPs are being asked to do more with no additional funding and support is being provided to those patients, and not happy with option 1 in terms of referral back to GP. It was noted that there were clinics within the Liverpool area that have been disbanded and those patients have been referred back to GP. Additionally, it was noted that this was not just for patients with long COVID, but that there are significant waits for patients with conditions such as CFS and some fibromyalgia patients as well so support for option 3 was given.

In response to this it was acknowledged that all patients who had been discharged from existing services had a clinical review before discharge, so some of them were referred on, and it was the view that the ones that were discharged back to the GP was the specialist service making that judgement.

In general Board members felt that the best option was 3, but requested that whatever model or pathway was worked up to look at the shifts with all parts of the providers (not just the lead provider) to be reimbursed and to look at all elements of the pathway being funded carefully and appropriately.

Healthwatch also supported option 3 of the options available adding that it was key to learn from patients and how the service worked against the short term hospital based service, it was noted long COVID was a difficult illness to live with and if we can use this to support both cohorts of patients that would be ideal.

Additionally the Board were asked how it would like to proceed following decision, asking if Board wished to see this again or through committee. It was agreed that it did not need to come to Board again, but would be managed through the appropriate Committee.

The Board;

- **noted the engagement and research process undertaken to date in developing the short list of options above**
- **endorsed the recommendation of the Executive Committee to undertake further work to explore in more detail how the proposals in Option 3 effectively balances meeting the needs of patients alongside delivering the most cost-effective option**

ICB/05/25/15 C&M Sub Fertility Clinical Policy Status and Options for consideration

Prof Rowan Pritchard Jones talked to the report and outlined that there has been hard work over three years to bring harmony and have this across nearly 100 policies now. Some were inherited from the CCGs, and this policy is and extensive one. Again there has been a huge amount of work done on this, thanks were given to all involved.

Today's report looks to consider an interim position to manage this policy, with the request for Board to take this into consultation and to consider exactly what we want to consult on.

Despite being a national health system, there is essentially a national postcode lottery we have inherited across Cheshire and Merseyside and there is variation of between one and three cycles being made across our nine places.

It was noted that 66% of our ICBs offer a single cycle, and that is the case within our neighbouring ICBs. This is a very complex situation as success rates vary through a number of factors.

For context, ballpark figures for a 34 year old female embarking upon treatment would be;
One cycle gives 30% success, Two cycles gives an increase of 15% to 45% success and where three cycles are offered there is an additional 10% to 55% success, sadly this is a law of diminishing returns for our patients. It was added that on average for our patients, it takes 1.6 cycles of care.

This gives significant challenge as to what we can afford as a healthcare system, and currently we invest £5m into this mixed economy of IVF cycle. Therefore we are looking to harmonise this policy. If we were to harmonise to the rest of England with a single cycle we would spend £3.7m (which would free £1.3m to invest into other areas). If we were to harmonise to two cycles, it would give the current spend to a cost pressure of £40k, and if three cycles then that cost pressure increases to £5.7m.

It was outlined that this was not for Board to make a decision what to do (i.e. how many cycles to offer) but more about a decision as to how to proceed with this. The opinion is that we ought to proceed into consultation. If this is the case, then we do need to decide what offer we are consulting in, and what the future harmonisation might be.

Impact assessments are also available as are QIA (quality impact assessments) for both one cycle and two cycles and the impacts are broadly similar. Additionally, there are some minor other changes other than cycles being proposed in the harmonisation policy related to smoking, BMI, alcohol intake and age etc, this will also bring us in line with NICE.

Another positive is that a harmonised position is a much fairer policy and more consistent policy and would look to remove the postcode lottery. The policy that we are proposing may disadvantage some same sex couples (due to the protective characteristic of sexual orientation) as the current policy requires some self-funding of part of the cycle. However, the Government have pledged to remove this inequality benefit over the next 10 years, but this impact will not be felt by anyone currently going through this.

Another impact is that people on low income will not be able to self-afford a second cycle (if we go to a single cycle) and this will be considered in detail when we go to public consultation.

It was a clear view that we must consult, and the question to the Board is to consult on whether it is one or two cycles.

Overriding issues is that we have to drive consistency, and if colleague ICBs are offering a single cycle then we should follow suit.

Noted that this is a really emotive topic and is so important to families and to so many people, recognised that nationally we have a postcode lottery, and then with Cheshire and Merseyside we have a further postcode lottery whereby people living in the same road can have different offers available.

For context it was stated that if hip replacements only had a 30% success rate, would we still offer it? and that a 30% success rate needs to be taken into consideration when looking at the finite resource.

Concern was raised that we may be looking to consult without putting the option supported by clinical advice and it was questioned as to what the scale of this service was; how many cycles do we provide across Cheshire and Merseyside? In response it was advised that we provide close to 1000 cycles currently.

It was recognised that we need to be mindful of patients who are already going through this process, noting that it is stressful and especially if they are part-way through a programme and pathway therefore we need to be mindful of the correct and appropriate communications in this and to see the transitional protection for people.

It was also key to note that whilst we may move to a harmonised policy subject to consultation, that is effectively our policy, but as with all policies there is the ability to request an IFR in exceptional circumstances, therefore we need to be really clear in the consultation that there is a route for exceptional circumstances.

The Board;

- **noted the work undertaken to date**
- **considered the options and recommendations of the Executive Committee and the Clinical Working group**
- **considered the items raised within the Quality and Equality impact assessment, and to determine the preferred option to progress to Public Consultation**
- **approved commencement of Public Consultation based upon the preferred option determined. It was agreed to go out to consultation on option 2, for a single cycle of IVF**, with the caveat, to have a broader understanding of why we are doing it, to be authentic, honest and to bring into harmony nationally and recognising the opportunity cost of investing in one area and not in another. To spend money that we do not have is to the detriment to the services that we may want to invest into the future. Agreed that we need to think about how we get these points across in the consultation.
- **noted the risks set out in relation to the approach and timescales**

ICB/05/25/16 2025/26 Operational and Financial Delivery Plan Update

The report is an update on the operational and financial delivery plan for 2025/26 and follows on from the March update regarding bring this in line with NHSE's planning guidance. The paper presented today brings this up to date and sets out the final plan that was submitted at the end of April 2025.

The ICB submitted a surplus plan of £15.3m offset by a provider position of £228m which resulted in a £178m system deficit plan, which was in line with the maximum deficit control total by NHSE for 2025/26. However, this did not initially meet NHSE expectations so the ICB was asked to improve the position between the end of March and the end of April. The paper also outlines some wider aspects of the 2025/26 operational plan. This has truly been a system effort with collaboration between commissioners and providers to get to this point.

Highlights include the plan to spend just over £8m for 2025/26 across a number of different areas in primary care, community care and mental health care, and also includes some aspects of specialised commissioning (as delegated to us from NHSE) there is more work to do on the pathways.

In order to have cost improvement and efficiency savings, there are some key drivers in the areas of prescribing, continuing care, mental health care packages, and managing demand in the system is key to making sure we have a good system planning approach to managing demand on the provider side.

Also, key to the delivery of cost improvements will be the impact on workforce numbers and costs around bank and agency spend along with improvements in productivity and efficiency in order to deliver.

There are some key measures around the referral to treatment standards, including the % of patients that are treated in 18 weeks and cancer standards around 62 days. Outlined that all but one of our providers have submitted a compliant plan. There is also a plan to improve corridor care and ambulance hand over times in line with national standards for UEC.

For mental health services, there is a focus on increasing and improving access to children and young people into our services including out of area placements and reduction of patient stays in community.

In terms of Primary Care, dental access, getting dental appointments and central access increasing around GP services as well as supporting the digital transformation.

More oversight is being taken within the ICB FCOG meeting and continual meetings with providers, along with a section around main risks in the system there are five key areas where we are working collaboratively and together to achieve the balance position within the financial year.

Concerns were raised about the lack of specific, tangible commitments in the plan regarding equality, safety, and prevention, and requested that future plans clearly list must-do objectives, investments, and associated risks. It was questioned as to how we hold the officers to account, and perhaps of more concern is the list of requirements that we do not mention some areas

The Board asked for the operational plan to clearly list the specific "must do" requirements from NHS England and other regulators, including operational milestones or objectives, so it is explicit what the board is expected to deliver. It needs clarity on what is being delivered, even if it is the same as last year, and for a risk assessment to accompany these objectives, highlighting any areas where delivery may be at risk due to affordability or other factors. Without this clarity, it would be difficult to track whether the board is making progress or going backwards on key issues, and also having an understanding of how the full £8 billion budget is being used to deliver these priorities.

Action: a more detailed annual delivery plan is to be brought back to the Board, including specific must-do objectives, key milestones, risk assessments, cross referenced with the NHS 10-year plan if it has been released in enough time, so as to ensure priorities and investments

In relation to Urgent Care there is commitment to reduce corridor care by 50%, does that mean that we are just accepting that corridor care continues, it was asked how much corridor care there was in May, but that it now seems that it has become a part of what we do, how can we get out of this as it is not a respectful way of treating patients.

In response it was advised that partly as a result of the planning process and that we are reviewing all expenditure, to justify this and to check that it adds value. In respect to some of the specifics there are some pre-committed and we are looking to justify these and that they are correct.

Looking to be proactive rather than reactive as we are spending £8bn in our system, we want to move this to be more primary community, and if the reactive work stops this is then about how we move the

money. It is activity based as per national guidance and are looking to move back to this and away from block payments.

The annual delivery plan was signed off at last Board, then in July, hopefully we will have the 10-year plan. The annual plan that clearly articulated the must do from NHSE and regulatory bodies and will be clear as to what we are going to invest in those areas.

In response to corridor care it was outlined that it is not an accurate recording but is approximately 127 patients on a daily basis with the primary focus on operational planning to access readily urgent and emergency care. There is a key metric of 30 mins for the ambulance care to access the patient, and a 4-hour to treatment, along with the metric that no one should be spending more than 12 hours in that place. In terms of corridor care, this is a way of a balancing the risk, and if mitigated it would be at the detriment of another aspect of urgent care and the sentinel metrics.

Also, one of the biggest drivers of financial pressure for us, is the right thing to do across the entire pathway and for the patient.

Board will see the improvement plan that we are about to embark on. In terms of whether we are accepting corridor care, absolutely not, we have enough beds in our system, there is capacity and resource, and we have financially invested in Cheshire and Merseyside on emergency care. We need to take stock on our criteria to reside as we are a national outlier, but we have starting to see inroads on this. It will be key to see what will be different this year and this will be useful for the Board to see. Anecdotally, it was reported that, today in Liverpool alone, we have to question why there are 88 patients in an acute bed who do not need to be in that bed, and this is replicated across the region. Corridor care should be the exception not the rule.

Action: a more detailed improvement plan to come to the next board meeting, focusing on reducing corridor care and improving patient flow

The Board;

- **noted the progress made on both revenue and capital financial plans for 25/26 since the end of March plan submission**
- **noted a revised submission of a £178.3m system deficit plan (£50.3m surplus for the ICB / £228.6m deficit for NHS Providers) in accordance with NHS England control totals**
- **noted that the ICB has submitted compliant plans in respect of key operational standards**

ICB/03/25/17 C&M Polypharmacy Programme Briefing

The position is stark, we are the third highest system of the 42 in terms of the average number of unique medications prescribed to our patients. Additionally, we are the second highest nationally in terms of patients being on more than 10 unique medications, and we are the highest in country for patients being prescribed 15-20 medications.

In line with this, in terms of the consequence of polypharmacy that we are also sixth highest in the country for falls resulting in admission for patients over 65 years old.

In 2024/25 there has been £1m of prescribing spend was taken out across the 9 places to improve the outcomes of our patients, to actively tackle and improve our inefficiency.

The elements that make this up, whether that is GPs being able to review patients using risk stratification, and the population of health tools that have been embedded, the data into action (DIA) programme allows us to search for our patients and risk stratify them in order to track the impact (falls reported etc). We have stand out excellence, Sefton Hub for example can be measured, where the need for GP appointments has been reduced by 9% which is almost 3k appointments along with a 32% reduction in A&E attendance in the six months following discharge.

It was noted that from a Board perspective it looks really good to look at the benefits at Sefton Place, and a point of clarity in that it was not 3k appointments that were not delivered, rather these were appointments that were then offered to other patients. This is seen as a gold standard and questioned how we can set this and recommend this for other patients.

Outlined that there is a void between primary care and secondary care and between the number of weeks to receive a letter from the hospital to the GP, it was suggested that if GP pharmacists were part of the MDT, shared care record could also be vital in reducing the discrepancy and learn from where things have gone well and where we can look to reduce the bureaucracy between primary care and secondary care.

Totally support the work to address polypharmacy, it is a well-established safety risk and can improve outcomes by actually taking people off many medications that are not needed. It was questioned after the programme cost support delivery of £2.4m of savings, how much was being invested to get this saving?

Comments gave support and saw the great benefit of developing patient champions, and some best examples of working nationally is where patient application in the mental health space. Also, the voluntary sector and the impact of social prescribing, and whether we are really maximising this.

Polypharmacy group and the importance of patient voices to be included, along with the learning in the system and into the future, and in terms of governance structure, having a resource / people for the learning.

The Board;

- **noted the current position and progress of the programme**
- **endorsed the ICB Polypharmacy Programme and approach**
- **noted further reporting will be via the ICB Quality and Performance Committee**
- **requested that a further report is brought back to Board in 9 months time outlining the impact and the realisation of the investment and details on patient experience**

ICB/03/25/18 C&M Integrated Research and Innovation System (IRIS): Research and Innovation Priorities

Greg Irvine stated that this was last reported back in January 2024, which fulfilled the plans around maximising the impacts.

Highlights from the report show that we have firmly established IRIS as a national leader in research innovation, and a particular strength has been the work in primary care and the community around research innovation. Out of 349 practices, half are engaged in research, with 131 actively recruiting and 53 delivering commercial research. The region is in the top three nationally for primary care recruitment and commercial research activity, particularly excelling in deprived communities due to an inclusive approach and strong networks.

Work aligned to the delivery plan and really strengthening the research in primary care, public health and social care.

Significant infrastructure investment has been secured, including £1.2M and £4.2M capital funds for primary care research networks, mobile units, and engagement with the voluntary sector. The region also received £5.7M in competitive system-wide funding for commercial research delivery centres.
It was outlined that there was no ask for funding, for every £1 that has been invested in funding is thought to bring back £13 into the local wider economy.

There is strong collaboration with universities, NIHR, local research alliances, and innovation partners. Over £10M has been secured for Civic Health Innovation Labs, and mental health research has attracted £14M, leveraging £48M in external investment.

The Chair gave thanks and that it was pleasing to hear the progress that has been made in the last 12 months or so, he added that throughout the morning the Board have heard the work of innovation and learning has been consistently spoken about. This is exactly what we want to do to measure and innovate.

This really sets out what we want to achieve and what we suspect will come through in the 10-year plan, so it is very timely to do this.

In conclusion it is known that good quality research improved patient outcomes. The new world of the model ICB is coming through and working with adjoining ICBs we need to ensure to preserve the progress we've made on offering good quality research to those that we serve in the future. There may be new models of work going ahead to do this, and where possible all our patients should be given the opportunity to benefit from high quality research.

Action: a further report to come back to the Board in 9 months time updating the Board on the impact and realisation of investment and to include patient experience and outcomes.

The Board;

- **recognised the current duty to promote research and innovation is still held within the ICB to help support delivery of the Joint Forward Plan and ICB Delivery Plan**
- **supported the proposed priorities that build strategic partnerships to support the population health strategy and new neighbourhood models**

ICB/03/25/19 NHS Staff Survey results 2024/25 and next steps

Katie Horan presented this item, stating that this first came through in September to November last year, these are then published but it is only now that we can look at the detail, but there is thought to do it over 2 years going forwards to be able to implement things over a longer period of time.

Outlined that there is a summary of the ICB and ICS position within the paper, receiving a response of 73% which is higher than some of our other ICB colleagues but slightly down on last year (at 77%) but this is still a really good return rate and higher than all the ICBs. Engagement and morale scores are slightly lower than last year but remain above peer averages. Scores have stayed relatively stable over three years, despite ongoing organizational changes.

The papers show that we have compared ourselves across the three years that the ICB has been in existence on the people promise themes and we have stayed relatively stable across this.

Staff rated the organization as compassionate and inclusive. Areas needing improvement include recognition, reward, safety, health, and learning/development (L&D), with specific scores for "we are always learning" at 5.13/10.

It was noted that timings of when we have asked staff how they were feeling has not been great (the first year was management of change, the second year we had MARS and this year we have the running cost/ workforce cuts). Some scores are not where we want them to be as an ICB and there are plans to do some work around the Learning & Development offer.

Additionally, there has been analysis of the 199 free text comments and these were around recruitment freezes, transparent communications, mental health and well-being support which also supported other responses in the survey.

From these results, there have then been 1-2-1 meetings with all Executives and there have been open staff engagement sessions, which have been slightly redesigned following the announcement of the workforce cuts. These have been based on using the people promise frameworks and have asked staff what they would like in terms of support.

What staff were saying broadly fitting into what the staff survey results said, around availability of more health and wellbeing offers and these offers have been significantly increased in the last month or two. There are now offers of health checks for all staff, and the set-up of managers support circles, informal session of self-compassion, self-care sessions and these have been really well attended by our staff and positive feedback has been received.

Transparent communications has also been raised and there has been positive feedback since the launch of the bi-weekly WAO, also the availability of more face to face engagement sessions. Also, in the pipeline is for staff 'roadshows' along with simple thank you's' to staff and managers and the promotion of some of the reward and recognition schemes, teams of the quarter etc.

Also looking to do some more work on the Learning & Development officer and the quality of appraisals, also looking at what happens after appraisals. Staff are also keen on long service award recognition.

In terms of the ICS response rate, there was an increase to 58.3% which is slight up and whilst metrics are not where we would like to be in the system, it is moving in the right direction. Next step for the system is the quarterly ICS Retention Forum where all of our systems come together to learn lessons and share good practice.

It was questioned that there was no primary care staff responses featured in the staff survey, nothing across the four contractor groups, and therefore there is no understanding of the staff morale, this is spoken about every year but yet there is a whole cohort of NHS staff who are not being considered across the ICS as a system.

This was completely agreed with, and is an ongoing issue being looked at.

It was noted that a decision had been made last year with the LMCs and with the GP Practices not to complete the survey, but believe that it is being done this year and to look at this together across all four contractor groups, also noting that this is not just for the ICB to do the work, it is about practises and the contractor groups engaging with their staff also.

It was agreed for an **ACTION to work up a specification on this for primary care in its general sense to understand how much this would cost us and to make a decision on this through the Executive Committee.**

An offer was given by Prof Paul Kingston, around the infrastructure we have, which has been spoken about in terms of research and innovation, in that it can be used to support this and help in the form of independent evaluation if required.

The Board;

- **noted the ICB Staff Survey results**
- **endorsed the actions take to review, disseminate and respond to the NHS Staff Survey results 2024**
- **supported the areas of improvements identified from the staff engagement sessions**

Meeting Governance

ICB/03/25/20 Minutes of the previous meeting: 27 March 2025

The minutes of the previous meeting held on 27 March 2025 were accepted and recorded as a true and accurate reflection of the meeting

ICB/03/25/21 Board Action Log

It was noted that the Board Action Log was not in an appropriate format and that it needs completing and made accurate going forwards.

Action: Matthew to liaise with Executive leads to update Action log prior to July Board

Reflection and Review

ICB/03/25/22 Closing remarks and review of the meeting

Thank you for the meeting, and to the public for attending. There have been some really challenging discussions and conversations and some really heart of the matter in terms of taking difficult decisions.

Chair closed the meeting.

CLOSE OF MEETING

Date of Next Meeting:
24 July 2025

NHS
Cheshire and Merseyside

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

Held on MS Teams
Thursday 19 June 2024, 09:00am – 10:00am

DRAFT Unconfirmed Minutes

MEMBERSHIP	
Name	**Role**
Raj Jain	Chair, C&M ICB (voting member)
Cathy Elliot	Chief Executive, C&M ICB (voting member)
Mike Burrows	Non-Executive Member, C&M ICB
Mark Bakewell	Interim Executive Director of Finance, C&M ICB (voting member)
Christine Douglas, MBE	Executive Director of Nursing and Care, C&M ICB (voting member)
Prof. Rowan Pritchard-Jones	Medical Director, C&M ICB (voting member)
Prof. Hilary Garratt, CBE	Non-Executive Member, C&M ICB (voting member)
Erica Morriss	Non-Executive Member, C&M ICB (voting member)
Dr Ruth Hussey, CB, OBE, DL	Non-Executive Member, C&M ICB (voting member)
Ann Marr, OBE	Partner Member, (NHS Trust) (voting member)
Adam Irvine	Partner Member, (Primary Care) (CPCW) (voting member)
Trish Bennett	Partner Member, (NHS Trust) (voting member)
Prof. Steven Broomhead, MBE	Partner Member, (Local Authority) (voting member)
IN ATTENDANCE	
Dr Fiona Lemmens	Deputy Medical Director, C&M ICB (Regular Participant)
Anthony Middleton	Director of Performance and Planning, C&M ICB (Regular Participant)
Mike Gibney	Chief People Officer, C&M ICB (Regular Participant)
Clare Watson	Assistant Chief Executive, C&M ICB (Regular Participant)
Carl Marsh	Place Director, Warrington, C&M ICB
Prof. Ian Ashworth	Director of Population Health (Regular Participant)
John Llewellyn	Chief Digital Information Officer, C&M ICB (Regular Participant)
Matthew Cunningham	Associate Director of Corporate Affairs and Governance, C&M ICB
Ali Akbar	Senior Communications and Engagement Officer, C&M ICB
Ellen Loudon	Director of Social Justice & Canon Chancellor of Liverpool Cathedral, Vice Chair C&M Health and Care Partnership
Zoe Rubotham	(Minutes) Executive Assistant, C&M ICB

APOLOGIES NOTED	
Name	**Role**
Tony Foy	Non-Executive Member, C&M ICB (voting member)
Andrew Lewis	Partner Member, (Local Authority) (voting member)
Dr Naomi Rankin	Partner Member, (Primary Care) (voting member)
Warren Escadale	Partner Member, (VCFSE) (voting member)

Discussion, Outcomes and Action Points

Preliminary Business

ICB/06/25/01 - Welcome, Apologies and Confirmation of Quoracy

The Chair noted apologies and welcomed all present to the extraordinary board meeting, a single agenda item meeting seeking the board's decision to approve the annual report.

ICB/06/25/02 - Declarations of Interest

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

ICB/06/25/03 – Chairs Opening Comments

An extraordinary Board meeting was called as the timetabling of existing Board meetings did not allow for the timing requirements to review, make recommendations and approve the annual report and accounts for the ICB ahead of submission to NHS England. The chair emphasised, whilst there was not opportunity for a Q&A with board members today, a full presentation and recording of the meeting will be available on the Cheshire & Merseyside ICB website and opportunity for engagement with the public on the content contained within the report will be possible at the September 2025 AGM.

ICB Business Items

ICB/06/25/04 – NHS Cheshire and Merseyside Annual Report and Accounts 2024-25

The Chief Executive addressed the meeting and gave highlights of the report acknowledging the work of her predecessor Graham Unwin and wishing him well in his retirement

Key Points highlighted included:

- the report reflects a year of progress and collaboration across the system as the ICB working with a large number of trusts across nine places, serve a population of around 2.7 million people with well-established health and care partnership to improve health outcomes.
- real momentum in areas such as Integrated neighbourhood teams, which will continue in this financial year.
- digital innovation collective efforts to reduce health inequalities.
- considerable financial challenges, dealing with financial pressures and continuing to deliver safe and effective care for our local residents.
- further work is required around medium-term financial sustainability which remains a key focus.
- continued efforts to make sure that we are offering the most seamless access to care and the best possible care as close to home as possible.
- continuing to build the system that is compassionate, inclusive and responsive to local needs

The Interim Director of Finance highlighted to Board that that there is a legal requirement for documents to be submitted to regulators by 23 June 2025. The annual report and accounts have been to Audit Committee, who have conducted reviews and assurance on behalf of the Board. Auditors recommended minor changes to the accounts, of which the ICB were in agreement. All statutory and financial duties have been met.

Discussion, Outcomes and Action Points

There are three mandated sections within the annual report. A performance section, accountability section and the financial statements, some of which are subject to audits such as the remuneration reports.

Based on all the good work that the organisation has done through the year. Cheshire & Merseyside ICB has an unmodified Audit opinion for the 24/25 financial year.

The Interim Director of Finance outlined further that formal sign off of the accounts needs to be done by the Chief executive and auditors prior to submission on the 23 June 2025, and that full information will be published on the ICB website

Mike Burrows, Non-Executive Member confirmed that the Audit Committee had undertaken a thorough review of the annual accounts and the annual report for 24/25. He gave a short summary update to the Board with agreement from Committee chair who was absent today. In summary:

- the review included a detailed scrutiny of the financial statements, governance statement and the annual report narrative. Alongside consideration and findings of assurances provided by both internal/external audit and also feedback received by NHS England.
- the Committee was satisfied that the annual report and accounts presented a true and fair view of the organisation's performance and the financial position for the year ended 31st of March 2025, and that they reflected a comprehensive and transparent account of our activities and achievements.
- that the Report has been prepared in accordance with all relevant statutory and regulatory requirements, and that they have been subjected to a rigorous internal and external scrutiny process.
- accordingly, therefore, the Audit Committee recommends that the board formally accepts and approves the annual report and accounts for 2425 for submission to NHS England, in line with the national requirements.

Mike outlined that the Audit Committee are pleased with the Internal and External Audit opinions of the ICB and which is credit to all of the work undertaken over the last twelve months and gave thanks to all involved.

There were no questions or comments received from the Board.

Recommendations

The Board considered comments provided by the Chair of the Audit Committee, the substantial assurance around the ICB's system of assurance and associated mechanisms.

- the Board accepted the recommendations provided by the Chair of the Audit Committee.
- the Board approved the annual report and accounts 2024-25 and submission to NHS England.

CLOSE OF MEETING

Date of Next Meeting: 24 September 2025

End of Meeting

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

ICB Board Meeting Action Log

Updated: **15.07.25**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status	Recommendation to Board
IBC-AC-22-69	25/01/2024	**NHS C&M Quality and Performance Report**	Board to receive information on secondary prevention measures in primary care (link to QOF)	**Clare Watson**	Mar-25	*Discussion ongoing with Performance team regarding access to reportable data that can be included within the integrated performance report. Data metrics will be agreed at System Primary Care Committee and then update to be provided to the Board*	ONGOING	
ICB-AC-80	27/03/2025	**Integrated Performance Report**	Revised dashboard to be presented to the system primary care committee, incorporating recent changes from the planning guidance and letters from the Secretary of State to general practice.	**Anthony Middleton**	May-25	*Updated dashboard has been presented to the March 2025 SPCC. Changes are now standard for reporting to SPCC*	COMPLETED	Board is recommended to close the action
ICB-AC-81	27/03/2025	**Integrated Performance Report**	Future report to provide updates on the performance metrics and the impact of the virtual wards on cost-effectiveness, outcomes, and alignment with neighbourhood care mode	**Anthony Middleton**	May-25	*Performance Report has now has updated information in regarding virtual wards*	COMPLETED	Board is recommended to close the action
ICB-AC-82	27/03/2025	**Integrated Performance Report**	Provide updates on the impact of the hydration in care homes project and explore opportunities to broaden it out across wider area	**Anthony Middleton**			ONGOING	
ICB-AC-83	27/03/2025	**Director of Nursing Report**	Proposed System wide Safety Priorities to be brought for approval at the May Board.	**Chris Douglas & Rowan Pritchard Jones**	Sep-25	*Paper on the forward planner for Sept Board.*	ONGOING	Note that due to come to September Board
ICB-AC-84	27/03/2025	**Director of Nursing Report**	An update to come to the Board regarding the outcomes of the NHS England's paediatric audiology programme review and the subsequent improvement plans	**Chris Douglas**	Sep-25	*All visits to Trusts should be completed by September. Paper on the forward planner for Sept Board.*	ONGOING	Note that due to come to September Board
ICB-AC-87	27/03/2025	**Place Director Report**	Future report to come back to help Board understand the progress and impact of primary care network activities, ensuring alignment with broader neighborhood health models	**Clare Watson & Alison Lee**	Sep-25	*Update to be provided at September Board following review of Neighbourhood health model at July 2025 Board*	ONGOING	
ICB-AC-88	27/03/2025	**Improving Hospital Gynaecology and Maternity Services in Liverpool**	The Deputy Medical Director to Provide a detailed timeline and next steps for the women's services improvement project.	**Dr Fiona Lemmens**	Jul-25	*Timeline has been provided to Board members following briefings*	COMPLETED	Board is recommended to close the action
ICB-AC-89	27/03/2025	**Joint Forward Plan Annual Refresh**	The Assistant Chief Executive to present the full annual delivery plan and strategic tracker to a future meeting. This will include more detailed information on evolving the system, strategic commissioning roles, and building capabilities.	**Clare Watson**	Jul-25	*Update on the Annual Delivery Plan is due at the July 2025 Board Meeting*	COMPLETED	Board is recommended to close the action
ICB-AC-90	27/03/2025	**NHS Cheshire and Merseyside Financial Plan 2025-2026**	Director of Finance to provide an update on the financial plan and the ICS position in the next board meeting.	**Mark Bakewell**	Jul-25	*Update to be provided at the July 2025 Board meeting*	COMPLETED	Board is recommended to close the action
ICB-AC-91	27/03/2025	**Supporting Care Leavers into Employment**	Chief People Officer to develop a delivery plan and budget for the care leavers recruitment initiative and provide a report back to Board.	**Mike Gibney**	Nov-25		ONGOING	
ICB-AC-92	28/05/2025	**Chief Executive Report**	Mark Bakewell to develop and circulate to Board members a short factual note/briefing regarding NHS funding and fair shares funding and the formula behind it	**Mark Bakewell**	Jul-25	*Briefing is being circulated along with July 2025 Board papers*	COMPLETED	Board is recommended to close the action
ICB-AC-93	28/05/2025	**Integrated Performance Report**	Clare Watson to bring back a report to Board in July on GP appointments and access following submission to SPCC in June	**Clare Watson**	Jul-25	*Report is on the July 2025 meeting*	COMPLETED	Board is recommended to close the action
ICB-AC-94	28/05/2025	**Report of the Chair of Specialised Commissioning Joint Committee**	Clare to follow up with the Spec Comm leadership team to identify actions to reduce overconsumption of resources of SpecComm, with a report back to Board in three to six months.	**Clare Watson**	Nov-25	*Added to Forward Plan for November Board*	ONGOING	

ICB Board Meeting Action Log

Updated: **15.07.25**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status	Recommendation to Board
ICB-AC-95	28/05/2025	**2025/26 Operational and Financial Delivery Plan Update**	A more detailed annual delivery plan is to be brought back to the Board, including specific must-do objectives, key milestones, risk assessments, cross referenced with the NHS 10-year plan if it has been released in enough time, so as to ensure priorities and investments	**Clare Watson**	Jul-25	*Report is on the July 2025 meeting*	COMPLETED	Board is recommended to close the action
ICB-AC-96	28/05/2025	**2025/26 Operational and Financial Delivery Plan Update**	Mandy and Anthony to present a detailed improvement plan at the next board meeting, focusing on reducing corridor care and improving patient flo	**Mandy Nagra & Anthony Middleton**	Jul-25	*Report scheduled to be presented to Private Board in July 2025*	COMPLETED	Board is recommended to close the action
ICB-AC-97	28/05/2025	**Integrated Research & Innovation System**	A further report to come back to the Board in 9 months time updating the Board on the impact and realisation of investment and to include i patient experience and outcomes.	**Rowan Pritchard-Jones**	Mar-26		ONGOING	
ICB-AC-98	28/05/2025	**NHS Staff Survey Results 2024/25**	ICB work up a specification for primary care to be able to take part in the NHS Staff Survey, to understand how much this would cost us and to make a decision on this through the Executive Committee.	**Clare Watson & Mike Gibney**	Sep-25	*Added to the Executive Committee forward plan*	COMPLETED	
ICB-AC-99	28/05/2025	**Action log**	Executive Team to review action log and provide updates prior to the July Board meeting	**Matthew Cunningham**	Jul-25	*Action log circulated and updated prior to July Board*	COMPLETED	Board is recommended to close the action

Meeting of the Board of NHS Cheshire and Merseyside

24 July 2025

CONSENT ITEMS

All these items have been read by Board members and the minutes of the July 2025 Board meeting will reflect any recommendations and decisions within, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.			
AGENDA NO	**ITEM**	**Reason for presenting**	**Page No**
ICB/07/25/24	Board Decision Log **(CLICK HERE)**	For information	-
ICB/07/25/25	**Confirmed Minutes of ICB Committees** **Click on the links below to access the minutes:** • Audit Committee – June 2025 **(CLICK HERE)** • Children and Young Peoples Committee – June 2025 **(CLICK HERE)** • Finance, Investment and Our Resources Committee – May 2025 **(CLICK HERE)** • Quality and Performance Committee – May 2025 **(CLICK HERE)** • Quality and Performance Committee – June 2025 **(CLICK HERE)** • Shaping Care Together Joint Committee – March 2025 **(CLICK HERE)** • System Primary Care Committee – April 2025 **(CLICK HERE)** • Women's Hospital Services in Liverpool Committee – May 2025 **(CLICK HERE)**	For assurance	Page 270