NHS
Cheshire and Merseyside

Annual Report and Accounts 2024-25

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1. Performance Report

1.1 Performance Overview

The purpose of this performance overview is to provide a summary of NHS Cheshire and Merseyside Integrated Care Board's (ICB) activities during 2024-25, including the organisation's purpose, aims, performance and achievements during the year, as well as key issues and risks. In the interest of both brevity and accessibility - and in line with our corporate house style - the organisation will be referred to simply as NHS Cheshire and Merseyside.

1.1.1 Statement from the Accountable Officer

Welcome to the Annual Report and Accounts of NHS Cheshire and Merseyside, covering the period 1st April 2024 to 31st March 2025.

While this report contains many examples of successes, innovations and collaborations which have demonstrably improved patient care and experience, I need to start by acknowledging the tragedy that occurred in Southport last summer.

It is virtually impossible to overstate the devastating impact of the events of 29th July 2024. Our thoughts remain with the victims, all those who lost loved ones and everyone who was impacted by an incident so appalling that it not only shocked a community, but an entire nation.

In the face of such an atrocity it is important to pay tribute to a truly extraordinary response from the local NHS. Specifically, colleagues from North West Ambulance Service, Southport Hospital, Aintree Hospital, Alder Hey Children's Hospital and Manchester Children's Hospital who all cared for those who were injured under the most challenging of circumstances. I would also like to recognise the exceptional work undertaken by colleagues in other partner agencies and in communities in responding to and supporting events on the day and post incident.

It is in times like these that we must remember that the NHS touches people's lives at times of basic human need, when care and compassion are what matter most. In the very worst of circumstances, which we hope and pray never to see again, we saw the very best of our people and our NHS.

In 2024-2025, NHS Cheshire and Merseyside worked hard to make one of the country's largest and most complex regional health and care systems both easier to work with and to work within. Enormous progress has been made to simplify the way hospital services work. The inception of NHS University Hospitals of Liverpool Group brought together adult acute services in the city, while the introduction of shared leadership models in Warrington and Wirral is cultivating increasingly seamless relationships between acute and community care - helping to prevent unnecessary hospital admissions and safely discharge people from hospital sooner.

2024 also saw the publication of Lord Darzi's analysis of the NHS. It is certainly true that, at times, the NHS has been overwhelmed. However, it is also true that – for the first time ever – cancer survival rates in Cheshire and Merseyside have risen above the all-England average. This is largely due to a combination of targeted work, for example on lung health checks, and a step-change in access to early diagnosis.

Strong performance continues to be achieved in diagnostics more generally too. Cheshire and Merseyside was the first Integrated Care System to re-achieve (post-COVID-19) the key waiting list target for 90% of patients to receive a diagnostic test within six weeks. Cheshire and Merseyside is also delivering outstanding stroke outcomes – with Whiston Hospital ranked first and Aintree Hospital third in the country.

I am proud to report that access to primary care – a key priority for local people – was significantly improved in Cheshire and Merseyside in 2024-2025 too. There were more than 500,000 additional primary care appointments in the last year compared to the previous 12-month period, including an uplift in both in-person appointments and those supported by digital technology.

As has been widely acknowledged, waiting lists rose to an unacceptable level during the pandemic and it remains a priority to reduce the time people wait for planned care - in particular for those who have waited longest. Tireless work throughout 2024-2025 enabled more than 47,000 people who would have otherwise waited 65 weeks or more to be treated sooner. This performance was particularly creditable given the early months of 2024-2025 were marred by industrial action across a number of NHS staff groups. We are grateful to the Government for settling these disputes and creating a firmer footing for us to plan even faster access in the coming year.

Despite these achievements, the Cheshire and Merseyside health and care system continues to consume more than its share of resources. The system has an immediate financial problem that is associated with overspends in our NHS providers and the speed at which they can adjust from the Covid period financial regime back to a more regular NHS contracting process. However, the ICB has a medium-term problem in that we consume more than our fair share of the overall NHS resource and under the present NHS national policy our funding is being reduced by 0.5% per annum to address this.

On 30th April 2025 the ICB submitted a compliant plan to NHS England for achieving a system control total for the 2025-2026 period and which has resulted in both the ICB and every Cheshire and Merseyside Trust provider taking on additional cost improvement requirements (resulting in an aggregate deficit across the 16 NHS providers of c£228m offset by a surplus for the ICB of £50m). This compliant plan will enable us to spend our allocation, plus an additional £178m of deficit support funding (equivalent of 2.2% of our allocation) during the 2025/-6 financial period.

Whilst agreeing a plan was essential to securing the deficit support and cash to underpin this, our attention must turn now to the effective delivery of the plan and effectively mitigating the risks. The Cheshire and Merseyside system must also

ensure that it returns to balance within three years, meaning that system expenditure must not exceed allocation.

In the final weeks of 2024-2025, the Government indicated significant changes to all ICBs which will redefine our role and purpose and require us to substantially reduce our running costs. Guided by a 'Model Integrated Care Board Blueprint', it is with a heavy heart that one of the last things I will do as NHS Cheshire and Merseyside Chief Executive is prepare a plan which will reduce our staffing costs by at least 25% by Quarter 3 2025-26. This is absolutely no reflection of the standard of service of any of my colleagues or their contribution to the NHS, but a requirement of all public services to reduce cost and increase productivity.

On a personal note, 2024-2025 marked my final year in the NHS after 42 years of public service. I would like to thank the dedicated staff who work across all parts of the local NHS for their compassion, dedication and commitment. It has been an honour to end my career serving the people of Cheshire and Merseyside.

Finally, I would like to wish my successor Cathy Elliott all the very best as takes on the position of the Chief Executive of the ICB on 01 June 2025.

Graham Urwin

Graham Urwin
Chief Executive (1st July 2022 – 31st May 2025)

I am delighted to have the opportunity to take up the role of Chief Executive for NHS Cheshire and Merseyside. This is an exciting as well as challenging time for the NHS but I know from experience that I am joining a system with a strong tradition of close partnership working, and this will be essential as we work together to face these challenges, transform services and improve care to make a real difference to the communities of Cheshire and Merseyside.

Despite the challenging backdrop we look forward to the upcoming launch of the Government's 10-Year Health Plan, the opportunity to build models of neighbourhood health for the future and the prospect of further embedding initiatives which help to deliver the 'three shifts', namely: 1) Moving care from hospitals to communities 2) Making better use of technology 3) Focusing on preventing sickness, not just treating it. In Cheshire and Merseyside, I am pleased to report that this challenge will begin with strong foundations due to our already innovative use of data and technology and collaborative health and care partnerships working in communities.

We invite you to read this Annual Report to find out more about the breadth of what NHS Cheshire and Merseyside achieved alongside our partners in 2024-25. Please send any comments via email to: communications@cheshireandmerseyside.nhs.uk

Cathy Elliott

Cathy Elliott
Chief Executive (from 1st June 2025)

1.1.2 Purpose and activities of the organisation

NHS Cheshire and Merseyside was formally established on 1st July 2022 and is one of the largest Integrated Care Boards (ICBs) in England, working across and within nine local authority areas known as Places.

NHS Cheshire and Merseyside is the statutory NHS organisation responsible for planning and arranging for the provision of healthcare services for more than 2.7 million residents and forms part of the wider Cheshire and Merseyside Integrated Care System, alongside:

- **Cheshire and Merseyside Health and Care Partnership**: a statutory joint committee between NHS Cheshire and Merseyside and the nine local authorities, with membership and attendance from a range of partners from across the integrated care system.
- **Nine Place-Based Partnerships**: partners working together on local authority footprints to support the integration of health and care services and delivery of joint Health and Wellbeing Strategies.
- **Two NHS Provider Collaboratives**: partnerships that bring together multiple NHS trusts (providers of NHS services including hospitals and mental health services) to work together at scale. In Cheshire and Merseyside, there are two NHS provider collaboratives:
  - Cheshire and Merseyside Acute and Specialist Trust (CMAST)
  - Mental Health, Community and Learning Disability Collaborative (MHLDSC).
- **48 Primary Care Networks**: groups of GP Practices working together - key building blocks of the NHS Long Term Plan.
- **c19,500 Voluntary, Community, Faith and Socical Enterprise sector (VCFSE):** a range of organisations contribute to the sector being a key strategic partner for public sector organisations - providing research, consultation and commissioning services on top of frontline service delivery across a number of themes relating to community need and addressing inequalities.

NHS Cheshire and Merseyside also works closely with the neighbouring Integrated Care Boards of NHS Greater Manchester and NHS Lancashire and South Cumbria, and NHS England in the commissioning of a number of specialised services across the North West.

The four core purposes of all Integrated Care Boards are:

- **Tackling health inequalities in outcomes, experiences and access** - *We will identify where inequalities exist and focus on proactively addressing these inequalities in everything we do.*
- **Improving outcomes in population health and health care** - *We will take an evidence and intelligence-based approach to turn data into action in addressing where we need to improve outcomes the most with a focus on moving from treatment of ill-health to prevention.*
- **Enhancing productivity and value for money** - *We will maximise the value of every pound we spend to ensure that we are best meeting the needs of our patients and communities; investing our resources where evidence shows we can have the greatest impact on outcomes.*

- **Helping to support broader social and economic development** - *We will work to support our communities by growing our role as Anchor organisations investing in our communities economically and environmentally.*

All Together Fairer: Our Health and Care Partnership Plan was approved by the Cheshire and Merseyside Health and Care Partnership and articulates the shared vision, mission and purpose of the Integrated Care System:

It targets our partnership commitments around health inequalities from the Prof Sir Michael Marmot-led review '*All Together Fairer: Health Equity and the Social Determinants of Health in Cheshire and Merseyside'* and focuses on eight Marmot principles, describes three core principles (Figure 1) and sets out six headline ambitions (Figure 2) which system partners collaborate on.

Figure 1 Health and Care Partnership – All Together Fairer: Our Health and Care Partnership Priority Themes

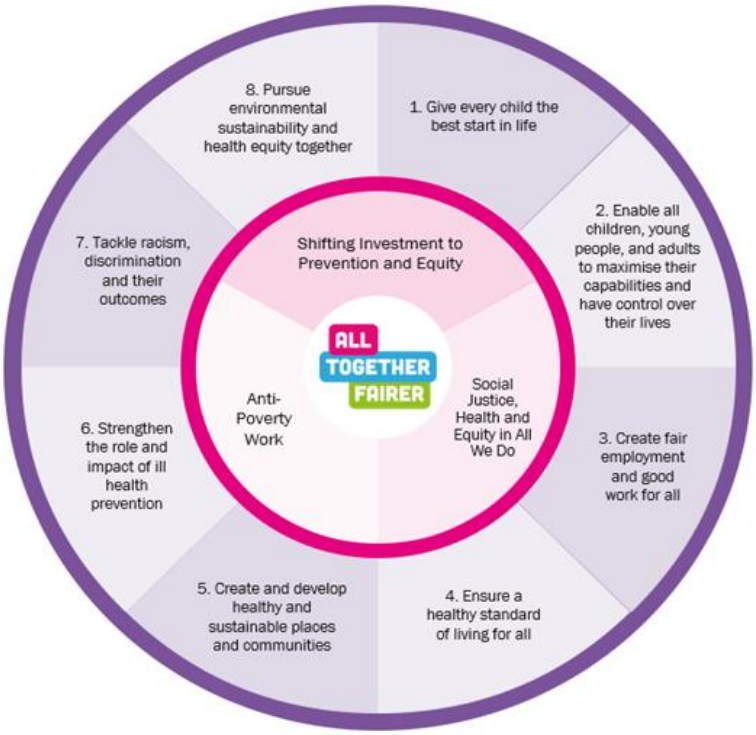


Figure 2 All Together Fairer Health and Care Partnership Headline Ambitions

All nine Cheshire and Merseyside Health and Wellbeing Boards have committed to the recommendations in All Together Fairer to form a 'Marmot Community' - reflecting the strong support, enthusiasm and shared ambitions of all partners.

All Together Fairer: Our Health and Care Partnership Plan and our Joint Forward Plan have been delivered via a two-way process combining the collective priorities from the nine local Joint Health and Wellbeing strategies alongside a number of Cheshire and Merseyside priorities.

Both documents build on local strategies and additional work to establish Cheshire and Mersey-wide priorities. These have been assessed and developed through work with our Cheshire and Merseyside Public Health Collaborative (CHAMPS on behalf of nine Places and Directors of Public Health) and has used a number of sources including Office for Health Improvement and Disparities (OHID) data to identify the common thematic areas to prioritise.

The three constituent elements of the Cheshire and Merseyside Joint Forward Plan articulate how we will work as a system to deliver on our priorities and statutory duties under Section 14Z52 of the Health and Care Act. NHS Cheshire and Merseyside has consistently consulted each relevant Health and Wellbeing Board on both the development of our plans and the content of this report.

In addition to this NHS Cheshire and Merseyside is committed to listening to people and communities to harness the knowledge and lived experience of those who use and depend on the local health and care system and provide an opportunity to improve outcomes and develop more effective services, removing barriers where they exist - specifically with relation to Children and Young People, vulnerable groups and those with protected characteristics.

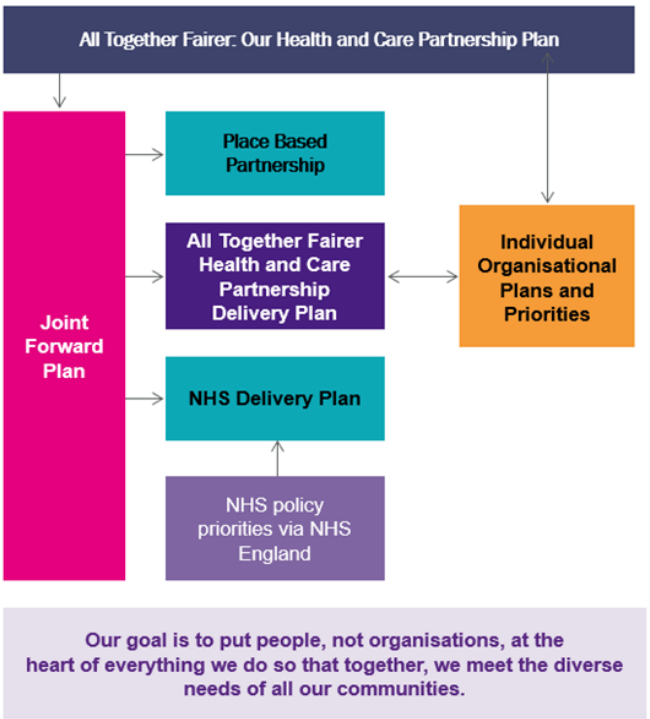
We also focus on PLUS groups – population groups defined by Integrated Care Systems who experience poorer than average health access, experience and / or outcomes across their communities. Priority has been given to understanding the health and wellbeing needs of PLUS and Health Inclusion groups using existing service data with further work to be undertaken where inclusion health needs are not currently recorded.

Population Health Management systems (such as the enhanced case finding tool) have been used to identify PLUS and inclusion health groups for priority action across prevention and early intervention services to help minimise health inequalities. Places are taking a targeted approach to PLUS and Inclusion Health groups based on Place specific need with local engagement with groups and communities to understand barriers to accessing services.

To support the delivery of All Together Fairer: Our Health and Care Partnership Plan, NHS Cheshire and Merseyside has created the Cheshire and Merseyside Joint Forward Plan 2024-2029 which contains three core elements:

- **All Together Fairer: Our Health and Care Partnership Delivery Plan** - focuses on the actions we are taking as a partnership to positively impact on the social determinants of health - the social, economic and environmental conditions in which people are born, grow, live, work and age - to reduce inequality in health. This has been shaped and informed by the nine local Joint Health and Wellbeing strategies, the defined Cheshire and Merseyside priorities and was signed off collectively.
- **Place Partnership Delivery Plans** – these have been developed locally in each of our nine Places, in response to their joint Health and Wellbeing Strategies, informed by Joint Strategic Needs Assessments and other identified local priorities. Place Partnerships and local plans have been aligned to our Joint Forward Plan priorities to help us address within the wider context.
- **NHS Delivery Plan (Cheshire and Mersey-wide)** – this builds on local Place-based plans and Cheshire and Merseyside priorities and describes how NHS Cheshire and Merseyside, partner NHS trusts and wider system partners intend to work together to arrange and provide services to meet our population's physical and mental health needs.

Figure 3 Overview of Plans



Our NHS Operational Plan 2024-2025 described delivery against nationally-determined priority areas in relation to clinical services, performance, quality and safety. It also included details on our workforce priorities and outlined our financial and capital plans.

These plans were distilled into an NHS Cheshire and Merseyside Annual Business Plan, which described the priority plans for the Integrated Care Board in 2024-25 aligned to the four core purposes and strategic objectives as follows:

- **Improve outcomes in population health and health care**: priorities including quality and patient safety, urgent and emergency care, primary and community services, elective care, cancer, diagnostics, maternity, neonatal and women's health, mental health, people with a learning disability and autistic people, frailty, children and young people, Shaping Care Together, Sustainable Hospital Services (Liverpool), Sustainable Hospital Services (East Cheshire), Mid Cheshire New Hospital Healthier Futures.
- **Tackle health inequalities in outcomes, experience and access**: priorities including prevention and health inequalities.
- **Enhancing productivity and value for money**: priorities including recovery programme delivery of financial benefits and use of resources, corporate development, workforce, digital and data.
- **Helping the NHS support social and economic development**: priorities including sustainability and partnerships and social value.

1.1.3 Performance Summary

Despite a challenging context for the 2024-2025 period, there were a number of notable achievements across the Cheshire and Merseyside region which are outlined further throughout this report.

In summary:

- NHS Cheshire and Merseyside was the first Integrated Care Board to re-achieve the national ambition that more than 90% of patients receive their diagnostic test within six weeks.
- Cheshire and Merseyside performed well against the two month (62-day) national cancer standard, exceeding the target each month
- Cheshire and Merseyside significantly increased access to transformed community mental health services for adults and older adults with severe mental illness - exceeding the national ambition
- Cheshire and Merseyside has delivered more Annual Health checks to people with Learning Disabilities
- The dementia diagnosis rate was consistently achieved following the introduction of new assessment pathways and promotional work to encourage people to attend for an assessment.
- People in Cheshire and Merseyside have continued to benefit from ongoing improvements to the Urgent Community Response (UCR) services. The number of accepted referrals into the service has increased by 70% since it began in 2023.

- GP practices across Cheshire and Merseyside are now delivering more appointments – by all available means – than in 2023-24, exceeding both the local and national targets.

It is recognised that the purpose of the annual report is to highlight both notable achievements and to provide further detail on areas where improvement is still required, this is outlined in the performance analysis section.

Financial Performance: NHS Cheshire and Merseyside delivered a surplus of £25.405m for the year to 31st March 2025 against its spending allocation.

NHS Cheshire and Merseyside has a number of financial duties under the NHS Act 2006 (as amended). For the year to 31st March 2025, NHS Cheshire and Merseyside achieved its financial duties as outlined in Table 1.

Table 1

Duty	Achieved
Expenditure not to exceed income	Yes
Capital resource use does not exceed the amount specified in Directions	Yes
Revenue resource use does not exceed the amount specified in Directions	Yes
Revenue administration resource use does not exceed the amount specified in Directions	Yes

1.1.4 Key issues and risks

The key issues, both locally and nationally, which impacted on NHS Cheshire and Merseyside in 2024-25, are summarised below – along with actions being taken to mitigate the impact on future delivery and performance:

- In the previous financial year (2023-24) only 71.4% of people attending an A&E Department were seen within 4 hours, 15.6% waiting more than 12 hours. Whilst these delays were seen in hospitals, they are a barometer of the challenges across the wider health and care system, which requires a whole-system response. Urgent and emergency care was one of the twin priorities of our focus on recovery in 2024-25.
- Demand for services and inflationary cost pressures are rising faster than budgets, and NHS organisations across the country faced a very challenging financial outlook in 2024-25. We agreed a budget with a £150m deficit with NHS England and ensuring we live within the resources available to us and to increase our productivity was also a priority of our recovery focus.
- In Cheshire and Merseyside there is a difference in life expectancy of 15 years (Male) and 14.7 years (Female) between those living in our highest and lowest deprivation wards. 35% of our population live in areas classed as deprived and 26% of our children live in poverty. Deaths due to heart disease, cancer, respiratory conditions, alcohol and drugs are higher than the England average. Evidence shows that it is often social

determinants of health which cause poorer outcomes and inequalities across our communities.

Our Board Assurance Framework holds the principal risks identified by the Board of NHS Cheshire and Merseyside as posing the most significant external and internal threats to the achievement of NHS Cheshire and Merseyside's strategic goals and continued functioning. Progress was made in mitigating these risks during 2024-2025, but action will be required over a number of years to reduce these to an acceptable level. The most significant principal risks identified by NHS Cheshire and Merseyside and the mitigating actions being taken are summarised below:

- there is a **critical risk** that a lack of urgent and emergency care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience. This is a significant strategic challenge described further in section 1.2.3.1 together with the actions taken to establish our System Co-ordination Centre and system-level operational planning and oversight.
- there is a **critical risk** that NHS Cheshire and Merseyside is unable to achieve a system financial balance. This is a significant strategic challenge described further in sections 1.2.10. Work continues across the system to deliver financial recovery and to agree a five-year Financial Strategy.
- there is an **extreme risk** that Cheshire and Merseyside is unable to retain, develop and recruit staff to the Integrated Care System workforce reflective of our population and with the skills and experience required to deliver the strategic objectives. This is a significant strategic challenge described further in section 1.2.3.14 together with the actions taken to deliver our Workforce Plan in 2024-25.
- there is an **extreme risk** that NHS Cheshire and Merseyside is unable to address inadequacies in the digital infrastructure and related resources leading to disruption of key clinical systems and the delivery of high quality, safe and effective health and care services. This is a significant strategic challenge wihich is being mitigated through the Five-Year Cheshire and Merseyside Cyber Security Strategy.

While not scored as a critical risk on the Board Assurance Framework, there is also a recognised risk that the time and resource to deliver against today's priorities, pressures and demands can divert attention and resource away from the delivery of longer term initiatives outlined within the Health and Care Partnership strategy that will work towards having a long lasting impact on population health.

1.2 Performance Analysis

There are a number of indicators that we monitor throughout the year to assess the performance of services and quality of patient outcomes in Cheshire and Merseyside. This work is guided by:

- the NHS Constitution - This sets out what patients have a right to expect from their local health and care services, but also what their responsibilities are to look after themselves.
- the NHS Oversight Framework (NOF) - This describes how the oversight of NHS trusts, foundation trusts and integrated care

boards operates. A set of oversight metrics has been published, applicable to integrated care boards, NHS trusts and foundation trusts, to support implementation of the framework. These are used to indicate potential issues and prompt further investigation of support needs and align with the five national themes of the NHS Oversight Framework: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability.
- delivering against the Cheshire and Merseyside Joint Forward Plan
- the NHS Operational Plan - This sets out the main areas Integrated Care Boards must plan for over the coming year. This includes specifying targets against which measurement will take place.
- quality standards and ensuring continuous improvement in the quality of services.

This performance analysis focuses on NHS Cheshire and Merseyside's performance against key constitutional standards and operational planning metrics over the year, covering how we measure progress, implement our Annual Business Plan, fulfil statutory duties and manage finances.

Wider examples of good practice and key delivery achievements are highlighted within case studies throughout the report.

1.2.1 How performance is measured

Integrated Care Boards (ICBs) are responsible for arranging health services and overseeing NHS services within their areas. The NHS Oversight Framework helps ICBs and NHS England work together on oversight, considering local needs and priorities.

NHS England oversees ICBs and NHS providers, with some operational responsibilities delegated to NHS Cheshire and Merseyside, in partnership with NHS England North West. ICBs ensure effective delegation to Place-based partnerships and oversee individual providers.

ICBs and NHS Trusts are categorised into four segments according to their support needs, from no support required (segment one) to intensive support (segment four). Of NHS Cheshire and Merseyside’s 16 NHS Trusts: two are in segment one (high performing), eight in segment two (with improvement plans) and six in segment three (requiring significant support). There are no Cheshire and Merseyside NHS Trusts in segment four (Table2).

Providers in segments one and two are overseen via regular contract, quality, and performance arrangements, while segment three NHS Trusts are supported through dedicated oversight forums focused on improvement plans and tailored support.

Table 2

Provider Trust	NOF Segmentation
Liverpool Heart and Chest Hospital NHS Foundation Trust	1
The Walton Centre NHS Foundation Trust	
Alder Hey Children's Hospital NHS Foundation Trust	2
Bridgewater Community Healthcare NHS Foundation Trust	
Merseycare NHS Foundation Trust	
Mersey and West Lancashire Teaching Hospitals Trust	
Mid Cheshire Hospitals NHS Foundation Trust	
The Clatterbridge Cancer Centre NHS Foundation Trust	
Warrington and Halton Teaching Hospitals NHS Foundation Trust	
Wirral Community Health and Care NHS Foundation Trust	
Cheshire and Wirral Partnership NHS Foundation Trust	3
Countess of Chester NHS Foundation Trust	
East Cheshire NHS Trust	
Liverpool University Hospitals NHS Foundation Trust	
Liverpool Women's NHS Foundation Trust	
Wirral University Teaching Hospitals NHS Foundation Trust	

The NHS Oversight Framework emphasises delivering NHS planning guidance priorities, the NHS Long Term Plan, NHS People Plan and local Integrated Care System goals.

The framework includes:

- five national themes – 1) Quality of care, access and outcomes 2) Preventing ill-health and reducing inequalities; 3) people; 4) finance and resources; and 5) leadership and capability.
- high-level oversight metrics at both Integrated Care Board and Trust levels.
- a sixth theme for local strategic priorities, recognizing unique local challenges, Integrated Care Partnership strategies, and promoting collaboration to address health and care challenges and support social and economic development.

1.2.2 Performance monitoring systems and processes

NHS Cheshire and Merseyside has a Quality and Performance Committee to:

- review integrated performance reports - focusing on quality, safety, patient experience and outcomes.
- monitor contract quality performance monthly.
- identify and review significant Key Performance Indicator (KPI) variations and management actions.
- quantify contract over/under-performance in financial and activity terms.
- benchmark recovery plans and report underperformance.
- oversee procurements and major service changes, ensuring quality, safety, and compliance with legal requirements.

The Board of NHS Cheshire and Merseyside an Integrated Performance Report at each of its meetings on key metrics from the 2024-25 operational plans, including Urgent Care, Planned Care, Diagnostics, Cancer Care, Mental Health, Learning Disabilities, Continuing Healthcare, Health Inequalities, Quality, Workforce and Finance. These reports summarise issues, impacts and mitigations.

Programmes in the Annual Business Plan focus on key outcomes, using a robust management approach aligned with the Board Assurance Framework for progress reporting.

NHS Cheshire and Merseyside is fully engaged with the Cheshire and Merseyside Health Care Partnership (HCP). Working closely with Integrated Care System (ICS) partners, NHS Cheshire and Merseyside's Strategy and Collaboration team have been responsible for the co-ordination and development of the All Together Fairer: Our Health and Care Partnership plan. This development work has included a direct link to Place, including via local Health and Wellbeing Boards.

NHS Cheshire and Merseyside is also committed to the implementation of the Cheshire and Merseyside All Together Fairer Plan, with its Chair also fulfilling the role of HCP Co-Vice Chair. While the system plan is owned and overseen by Cheshire and Merseyside HCP, the NHS Delivery Plan linked to it is owned and overseen by NHS Cheshire and Merseyside.

The Joint Forward Plan and the NHS Delivery Plan outline our commitment to All Together Fairer and includes a commitment to the six headline ambitions and three key principles:

- shifting investment to Prevention and Equity
- Anti-Poverty Work
- Social Justice, Health and Equity in All We Do.

A governance structure has been in place through an All Together Fairer Advisory Board and Population Health Board and this structure has evolved into the next phase of ICS development with a strengthened focus on social determinants of health.

A challenge for the governance structure has been to ensure the link with activity happening through local authorities. This is provided through the Directors of Public Health and council-led Health and Wellbeing Boards in each borough – as well as the political leadership present on the Cheshire and Merseyside HCP Board.

1.2.3 Performance Metrics

The key performance metrics for NHS Cheshire and Merseyside, together with targets and regional and national comparators are set out in Table Three. The following sections provide further explanation of our performance and achievements, the extent to which we achieved our objectives in 2024-2025 and the further action we will take.

Table 3 Performance Metrics 2024-2025

Category	Metric	Latest period	Latest Performance	Local Trajectory	National Target	Region value	National value	Latest Rank
Urgent care	4-hour A&E waiting time (% waiting less than 4 hours)	Mar-25	72.6%	79.7%	78% by Year end	73.1%	75.0%	30/42
	Ambulance category 2 mean response time	Mar-25	00:32:43	-	00:30:00	00:25:31	00:28:34	-
	A&E 12 hour waits from arrival	Mar-25	16.2%	-	-	13.2%	9.7%	39/42
	Adult G&A bed occupancy	Mar-25	95.9%	94.7%	92.0%	94.6%	94.3%	31/42
	21+ day Length of Stay	Mar-25	1,454	0	-	-	-	-
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Mar-25	22.4%	12.6%	-	16.7%	14.4%	41/42
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Mar-25	659	0	-	991	7,381	-
	Number of 52+ week RTT waits, of which children under 18 years.	Mar-25	750	943	-	n/a	n/a	-
	Total incomplete Referral to Treatment (RTT) pathways	Mar-25	360,184	369,916	-	1,034,497	7,420,899	-
	Patients waiting more than 6 weeks for a diagnostic test	Mar-25	6.7%	5.0%	5.0%	11.4%	18.4%	1/42
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	Mar-25	76.4%	72.5%	85.0%	72.8%	71.3%	6/42
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Mar-25	95.3%	96.0%	96.0%	94.4%	91.4%	10/42
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Mar-25	76.3%	77.0%	77% by Year end	78.7%	79.0%	34/42
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028**. (rolling 12 months)	Jan-25	59.5%	70.0%	75% by 2028	58.6%	59.0%	21/42
Mental Health	Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Mar-25	21,770	21037	-	56410	617193	-
	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Mar-25	83%	60.0%	60.0%	72.0%	59.2%	8/41
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	Q4 2024-25	62.0%	-	60.0%	65.0%	66.0%	30/42
	Dementia Diagnosis Rate	Mar-25	67.6%	66.7%	66.7%	70.1%	65.6%	15/42

Category	Metric	Latest period	Latest Performance	Local Trajectory	National Target	Region value	National value	Latest Rank
	CYP Eating Disorders Routine	Mar-25	86.0%	**95.0%**	**95.0%**	78.0%	73.9%	**11/39**
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Mar-25	34,625	**37246**	**-**	121790	829308	**-**
	Number of people accessing specialist Community PMH and MMHS services	Mar-25	3,625	**3,420**	**-**	8,915	63,784	**-**
	Talking Therapies completing a course of treatment - % of LTP trajectory (YTD)	Mar-25	91.0%	**100.0%**	**100.0%**	88.0%	96.0%	**23/42**
	Talking Therapies Reliable Recovery	Mar-25	49.0%	**48.0%**	**48.0%**	46.0%	48.5%	**24/42**
	Talking Therapies Reliable Improvement	Mar-25	68.0%	**67.0%**	**67.0%**	67.0%	68.4%	**29/42**
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Mar-25	80	**≤ 60**	-	250	1,805	**25/42**
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Feb-25 YTD	92.3%	**85.0%**	**75%** by Year end	91.3%	90.0%	**10/42**
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Mar-25	85%	**70.0%**	**70.0%**	89.0%	84.0%	**25/42**
	Virtual Wards Utilisation	Mar-25	83.1%	**80.0%**	**80.0%**	66.0%	76.2%	**9/42**
	Community Services Waiting List (Adults)	Mar-25	43,198	**-**	**-**	86,588	767,553	**-**
	Community services Waiting List (CYP)	Mar-25	20,110	**-**	**-**	43,215	298,533	**-**
	Community Services – Adults waiting over 52 weeks	Mar-25	118	**1**	**-**	447	9,702	**-**
Primary Care	Units of dental activity delivered as a proportion of all units of dental activity contracted	Mar-25	95%	**100.0%**	**100.0%**	83.0%	79.0%	**25/42**
	Number of unique patients seen by an NHS Dentist – Adults (24 month)	Mar-25	937,773	**986,184**	**-**	2,635,531	18,143,666	**-**
	Number of unique patients seen by an NHS Dentist – Children (12 month)	Mar-25	333,475	**327,915**	**-**	1,009,570	7,074,655	**-**
	Number of General Practice appointments delivered against baseline (corresponding month same period last year)	Feb-25	95.7%	**-**	-	96.1%	97.3%	**-**
	Percentage of appointments made with General Practice seen within two weeks	Feb-25	90.2%	**85.0%**	**85.0%**	83.9%	82.8%	**-**
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Feb-25	7.02%	**10.0%**	**10.0%**	-	7.62%	**-**
	Total volume of antibiotic prescribing in primary care	Feb-25	0.98	**0.871**	**0.871**	-	1.00	**-**

Category	Metric	Latest period	Latest Performance	Local Trajectory	National Target	Region value	National value	Latest Rank
Integrated care - BCF metrics	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (average of place rates)	Q3 24/25	228.6	-	-	237.7	198.9	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Mar-25	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	542.5	-	-	346.4	351.0	-
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q3 24/25	65.5%	**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	62.6%	-	**65.0%**	61.1%	62.74%	**19/42**
	Smoking at Time of Delivery	Q3 24/25	6.1%	-	**<6%**	5.8%	5.50%	**27/42**
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.	Mar-25	15.8%	**12.0%**	**12.0%**	-	12.7%^	-
Continuing Healthcare	Standard Referrals completed within 28 days	Q3 24/25	73.10%	**>80%**	**>80%**	81.3%	72.475.5%	**29/42**
	% DST's (Decision Support Tool) completed that were in Hospital	Q3 24/25	0.00%	**<15%**	-	0.0%	0.0%	**1/42**
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q3 24/25	27.18	**<18**	-	23.05	17.29	**36/42**
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q3 24/25	53.85	**34.0**	-	47.82	33.97	**39/42**
Maternity	HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks)	Q4 24/25	0.5	**2.5**	**2.5**	0.8		
	Still birth per 1,000 (rolling 12 months)	Jan-25	3.02	-	-	-	4.0	-
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation (Healthcare associated)	12 months to Mar 25	770	**439**	**439**	2177	11728	-
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Feb-25	801	**518**	**518**	2113	14668	-
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation	Dec-24	0.986	**0.887 to 1.127 ***	-	1.000	-	-
	Never Events	12 months to Mar-25	22	**0**	**0**	-	-	-
Workforce / HR (ICS total)	Staff in post	Mar-25	74,600	**71,994**	-	198,623	-	-
	Bank	Mar-25	5,459	**3,246**	-	16,424	-	-

Category	Metric	Latest period	Latest Performance	Local Trajectory	National Target	Region value	National value	Latest Rank
	Agency	Mar-25	749	**980.8**	-	4,206	-	**-**
	Turnover	Dec-24	10.7%	**11.4%**	-	12.3%	-	**-**
	Sickness	Dec-24	5.6%	**5.8%**	-	5.9%	5.04%	**37/42**

1.2.3.1 Urgent and emergency care

Cheshire and Merseyside's urgent and emergency care services continued to experience significant operational pressures in 2024-2025, particularly during the winter period. This was in line with the rest of the country, with services dealing with challenges on four fronts throughout winter due to increased levels of flu, COVID, winter vomiting bugs and respiratory illnesses in comparison to previous years.

A by-product of such pressure could be seen via the number of patients who experienced ambulance handover delays - with ambulances required to wait for prolonged periods outside hospitals at some sites. Within hospital, all sites experienced issues with crowding in emergency departments and, as a result, a level of 'corridor care'. Wards within the hospitals had to accommodate additional patients to create flow from emergency departments and we continue to see a high percentage of patients delayed in hospital awaiting discharge who no longer have a clinical requirement to stay there. This created a sustained period of very high bed occupancy across the winter period.

NHS Cheshire and Merseyside was one of six systems nationally placed into 'Tier 1' due to challenging urgent and emergency care performance. As a result, all acute trusts across the footprint received support from the national Emergency Care Improvement Support Team (ECIST) with a specific focus on the introduction of 'Call before convey' – an initiative aimed at maximising utilisation of alternative to A&E such as same day emergency care, primary care services and urgent community response.

The number of patients seen, diagnosed, discharged or admitted within four hours in Cheshire and Merseyside Emergency Departments did not meet the expected trajectory of 77.2% in 2024-25. 71.4% of our patients were managed within four hours, however our system has faced significant challenges over the year and hospitals remain committed to improvement initiatives to reduce patient delays.

A number of initiatives commenced in-year included the use of four-hour guardians to ensure timely transfer to on-site urgent treatment centres and Same Day Emergency Care units, with frailty teams also co-located in emergency departments.

Ambulance Category 2 mean response times (18-minute national average response time) are above the national average. We continue to work with our ambulance and wider system colleagues to support timely ambulance handover at hospitals to enable ambulance crews to respond quickly to patients in the community.

North West Ambulance Service colleagues deploy clinicians within the control room to help triage calls and manage some patients' care over the phone without the need for an ambulance. Localised targets to support timely handovers have been set for 2025-26 ahead of the implementation of a national 45-minute handover protocol.

Where patients wait in emergency departments for 12 hours or more, this not only has a detrimental impact on their experience but can impact on their length of stay and outcomes.

NHS Cheshire and Merseyside consistently monitor delays in the emergency department to ensure accurate reporting, escalation of delays to hospital and system partners and to support improvement support to improve flow and reduce delays.

Adult General and Acute bed occupancy (the percentage of the available beds within our hospitals which are occupied at any one time) remains above the national target of 92%, sitting at 96%. NHS Cheshire and Merseyside is continually looking at ways to reduce bed occupancy - including directing patients to alternative out of hospital pathways where appropriate and focusing on reducing discharge delays.

The number of patients within our hospitals who are medically fit to be discharged is above the local trajectory at 19.5% This is a continual challenge, however urgent and emergency care partners across the system are working collaboratively with Place and local authority teams. This work is also aimed at reducing long length of stay by ensuring people receive the right care, in the right place, at the right time.

System Coordination Centre (SCC): During 2024-2025, NHS Cheshire and Merseyside's urgent and emergency care team expanded into a multi-disciplinary team to lead operations and improvement support for the system. The System Co-ordination Centre brings system partners together every day to help support and mitigate pressures.

The System Co-ordination Centre has supported providers to implement the nationally-mandated Operational Pressures Escalation Levels (OPEL) framework. This extends the current framework to reflect operational pressures, not only within the acute hospital but also community and mental health providers - enhancing system-wide escalation processes to support frontline teams during busy periods.

Real time reporting: SHREWD is a cloud-based tool displaying a range of urgent care metrics, giving users a real-time overview of what is happening in every part of our urgent care system – including A&E, hospital wards, social care, community and mental health services. This supports better system-wide decision making and escalation.

Case Study – Proactive Care for Frailty Patients: Integrated Community Care Teams, Wirral

Wirral's proactive care programme is bringing together the teams who support people with frailty and chronic disease to provide increasingly personalised and holistic care - with community trust frailty nurses now working as part of an integrated team.

Following referral via either a GP practice or community team, an initial visit is carried out by a lead clinician before a care plan is developed and agreed.

As patients with complex ongoing needs typically benefit from continuity of care, the whole team - including the community trust-employed staff - use the GP patient record for all clinical documentation.

Initial findings show that the service is reducing both GP appointments (15%) and hospital admissions (25%) for patients who are supported via the programme when comparing service use prior to the programme to three months after first contact with the team.

Case Study – Fast-track hospital discharge for patients whose homes need heating or electrical work, Knowsley

People who are struggling to heat their homes or find themselves in an emergency situation with a broken boiler are now able to apply for funding to repair or replace a central heating system or carry out identified electrical works.

Via NHS Cheshire and Merseyside funding, a fast-track service has been put in place to support patients who cannot be discharged from hospital because of required heating or electrical works. Once identified, a Knowsley Council contractor completes the necessary work as soon as possible to enable the discharge to take place.

This reduces the need for an unnecessarily long stay in hospital or temporary transfer to a residential home and reduces the risk of re-admittance because of a cold home.

1.2.3.2 Planned care

In 2024-2025, NHS Cheshire and Merseyside and the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) led significant initiatives to meet national waiting time ambitions, in collaboration with local NHS Trusts. Comprehensive strategies and operational measures adopted to enhance performance delivery.

Elective Performance

In 2024-2025 a key ambition was to ensure that, as a system, Cheshire and Merseyside maintained a zero 104 and 78-week position. Aside from a handful of exceptional circumstances, this was achieved.

A key delivery target for 2024-2025 was to eliminate 65-week waits. At the beginning of the year April 2024 Cheshire and Merseyside had 48,872 patients who needed to be treated in-year to achieve this ambition, with a total number of patients on waiting lists across the system of 388,933.

By the end of March 2025, we successfully reduced our 65-week waits to just 701 and a number of clinical specialities across the system have already gone even further to reduce waits - with some now below 52 weeks.

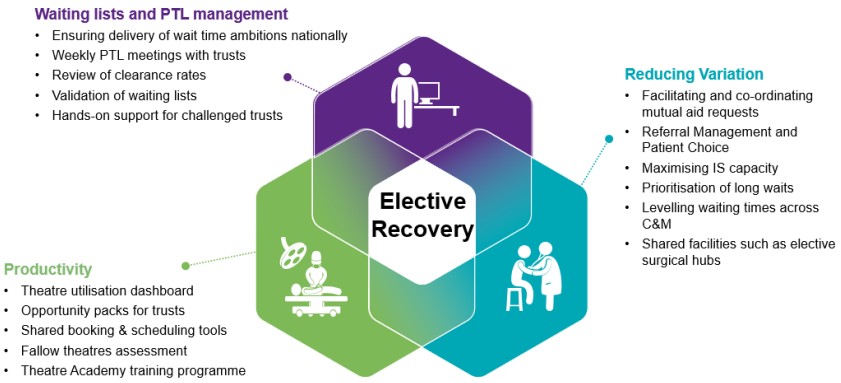
Across Cheshire and Merseyside, we also continued to focus on reducing our waiting times for Children and Young People. At the beginning of April 2024, Cheshire and Merseyside had 46,747 children on waiting lists – by the end of March 2025 this had reduced to 45,051 with 831 of these waiting 52 weeks or more for care.

Among a number of key successes in 2024-2025 which further enhanced our elective recovery approach was the adoption of a ‘further faster’ programme which specifically looks at both outpatient transformation and ensuring that patients are seen in the right setting at the right time. The system-wide Patient Initiated Follow Up (PIFU) rate has increased from 2.0% in April 2023 to 3.6% in January 2025 and is achieving the national median.

In 2024-2025 NHS Cheshire and Merseyside also implemented a system-wide validation improvement programme which focused on elective Referral to Treatment waiting lists, significantly improving performance against the national targets with a 20.3% improvement across 12 weeks, 29.9% improvement in 26 weeks and 17.5% improvement in 52 weeks.

A Health Inequalities dashboard was developed during 2024-2025 and will be ready for launch to all Trusts across Cheshire and Merseyside in 2025 to support equitable treatment and clinical decision-making.

Figure 4 Collaborative Strategies and Performance Delivery



NHS Cheshire and Merseyside and the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative focused on operational tactical measures to ensure the right capacity was available at the right time. By working closely with all Cheshire and Merseyside NHS Trusts, the optimisation of resources and implementation of efficient processes was prioritised. Key measures included:

Capacity Management
- rigorous assessment of current capacity and demand across all Trusts.
- strategic deployment of additional capacity resources to areas with the highest need.
- coordination of schedules to maximise availability and reduce waiting times through outpatient and theatre productivity

Performance Enhancement
- continuous monitoring and analysis of performance metrics.
- targeted interventions to address bottlenecks and inefficiencies.
- regular feedback loops to refine and improve operational strategies.

Mutual Aid and Specialty-Level Collaboration
- One of the cornerstone strategies has been the emphasis on mutual aid, wherein NHS Trusts support each other at the specialty level. This approach has allowed for a more dynamic and responsive allocation of resources, particularly in times of heightened demand. The benefits of mutual aid include:
  - ***Shared Demand Management***
    - redistribution of patient load among Trusts facing capacity challenges.
    - utilisation of specialty expertise across Trusts to manage complex cases.
    - enhanced communication and coordination to ensure timely patient care.

  - ***Operational Efficiency***
    - reduction in patient waiting times through collaborative efforts.
    - improved patient outcomes by leveraging the strengths of various Trusts.
    - fostered a culture of system working and shared responsibility.

Mutual aid was mobilised in the system to support with delivery of the national targets and equitable waiting times across Cheshire and Merseyside, with 1,285 patients mobilised across NHS providers, 7,727 patients supported by the independent sector and insourcing / outsourcing models and a further 123 patients supported regionally in the North West.

Through these initiatives, NHS Cheshire and Merseyside and the provider collaborative demonstrated a robust commitment to meeting national waiting time ambitions.

In 2025-26 we will work hard to achieve the 18-week Referral to Treatment standard by March 2029. We will also work tirelessly to ensure that the number of patients waiting less than 18 weeks for elective treatment will be 65% nationally by March 2026.

Diagnostics

Diagnostic performance across Cheshire and Merseyside was consistently in the top three nationally throughout 2024-2025.

In April 2024, we committed to meeting a target that at least 95% of patients should receive their diagnostic test within six weeks by the end of March 2025 after successfully meeting the 90% target in March 2024. This set Cheshire and Merseyside apart - both in the North West and nationally - as one of the few Integrated Care Systems to achieve this key performance measure.

Performance during 2024-2025 was consistently above 90%, aside from an anticipated dip to 89% in January 2025 due to winter pressures and the impact of a major incident within one of our Trusts.

Weekly data shows that in February and March 2025 we are recovering our position and forging ahead to meet the 95% target.

Methodology

What…	So What…	Meaning…
Evidence Based Best Practice	Networks work with departments re standardised referral criteria and optimised operating procedures.	✓ Only patients who need the test are accepted
Agreed levels of utilisation	Clinical leadership to agree set levels of activity per list. Royal College guidelines re expected activity levels used.	✓ Endoscopy lists to be booked to 12 points ✓ Echo slots to be not more than 45 minutes ✓ Set number of scans per hour delivered.
Near Real Time Productivity	Daily monitoring of in list activity, number of scans per hour and DNA rates.	✓ DNA rates less than 5% ✓ Meeting all productivity targets.

What…	So What…	Meaning…
Mutual Aid	Where trusts are working productively mutual aid can be requested.	✓ Over 5000 patients have been seen in a neighbouring trust with a shorter waiting time.
Patient Engagement and Feedback	The Diagnostic Board has a patient representative and hears a patient story each month.	✓ We learn from our patients about what matters and how we can go further and faster to deliver amazing diagnostics.

Case Study – Health Hub at Runcorn Shopping City becomes Community Diagnostic Centre, Halton

Halton Health Hub is an accessible clinical outpatient facility led by Warrington and Halton Teaching Hospitals NHS Foundation Trust and supported by local partners - from which a range of health, care and wellbeing services are delivered at the heart of our community.

The hub, located within Runcorn Shopping City, is accessible for residents in the most deprived wards of the borough, and is home to a range of services provided by partners across the health and care sector.

Preventative services such as smoking cessation and weight management services operate alongside acute hospital therapies (including dietetics and Musculo-skeletal), optometry and orthoptics services.

In 2024-25, the hub was expanded – courtesy of NHS funding – to host a variety of diagnostic services including respiratory clinics and sleep studies to form Runcorn Community Diagnostic Centre.

1.2.3.3 Cancer

NHS Cheshire and Merseyside worked closely with the Cheshire and Merseyside Cancer Alliance throughout 2024-2025 to continue to support providers to deliver the NHS Long Term Plan ambitions for cancer for our population.

Cheshire and Merseyside Cancer Alliance led the rollout of Targeted Lung Health Checks in 2024-25 which have made a significant contribution to earlier diagnosis, in addition to campaigning, community engagement, treatment pathway improvement, urgent cancer care, personalised care, health inequalities and patient experience programmes of work.

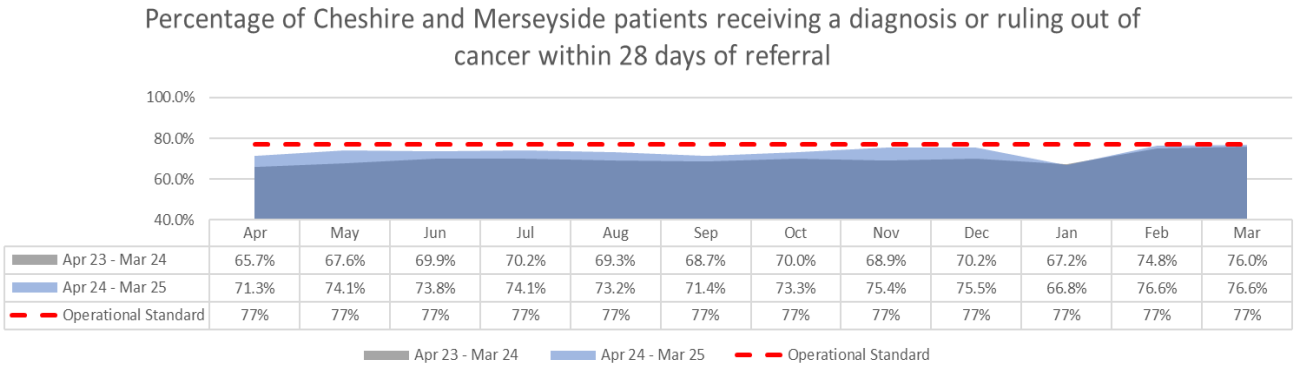
The focal delivery objectives for performance in year have been the headline constitutional standards (Table 4).

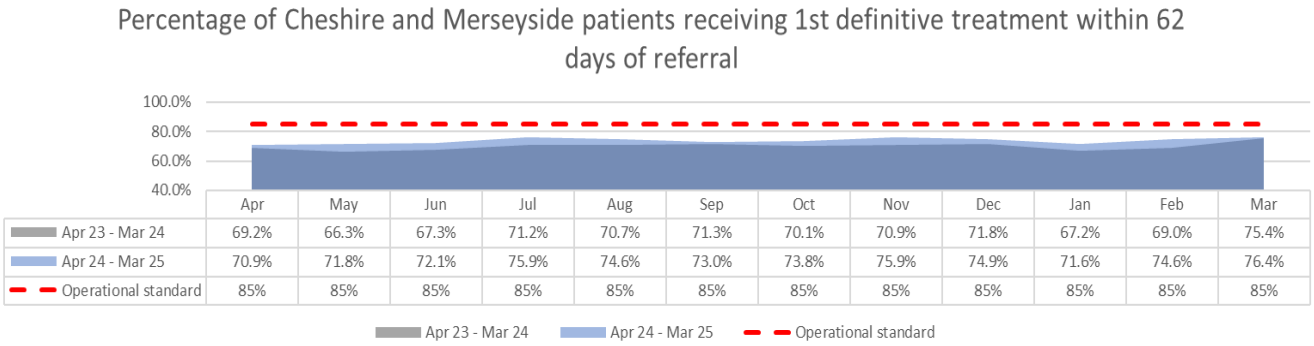
Table 4

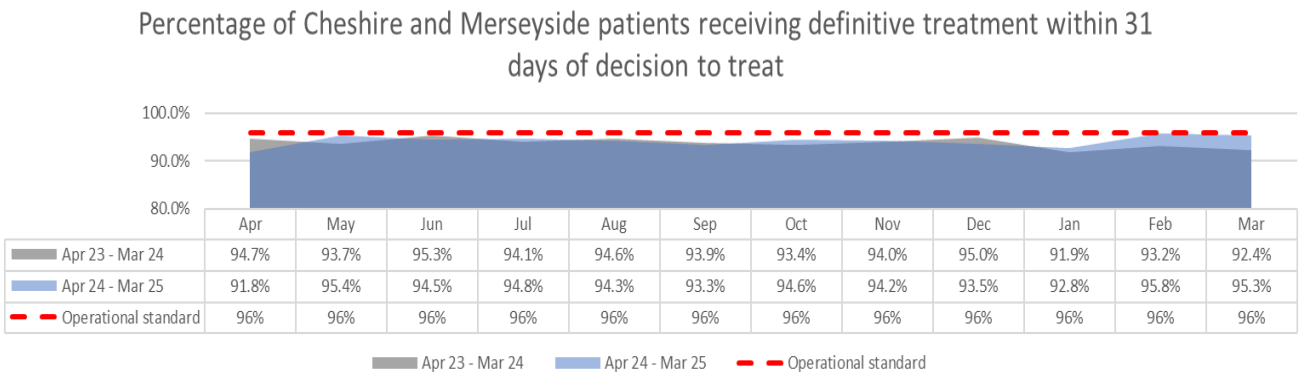
Maximum 28 days from: Receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of urgent referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer	75% (rising to 77% by the end of 24/25)
Maximum two months (62 days) from: From receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer 85%	85%
Maximum one month (31 days) from: From 'Decision to Treat'/Earliest Clinically Appropriate Date to Treatment of cancer	96%

Throughout 2024-2025, Cheshire and Merseyside performed well against constitutional national standards, particularly 62 and 31-day targets. However, faster diagnosis has been consistently behind the national average - there were no months in which all standards were met.

Figure 5 Population-based Cancer Waiting Times Performance April 2024 – March 202525







	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Apr 23 - Mar 24	94.7%	93.7%	95.3%	94.1%	94.6%	93.9%	93.4%	94.0%	95.0%	91.9%	93.2%	92.4%
Apr 24 - Mar 25	91.8%	95.4%	94.5%	94.8%	94.3%	93.3%	94.6%	94.2%	93.5%	92.8%	95.8%	95.3%
Operational standard	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

Improvement was made in each of the headline standards between 2023-2024 and 2024-2025. In March, the 202 2025 planning target was met for 62-days (ranking between 1st and 5th in each month of the year against 19 other alliances) and narrowly missed for Faster Diagnosis Standard (FDS), however, Cheshire and Merseyside finished the year 0.6 ppts higher than in March 2024 and was one of only two alliances to avoid performance worsening between February and March 2025.

Between April 2024 - March 2025 the overall percentage of patients receiving a diagnosis or ruling out of cancer within 28 days of referral was 73.5% compared to 69.9% in the previous 12-month period.

In some tumour sites, such as Lower GI, Gynaecology and Urology, more progress was made in FDS, with Cheshire and Merseyside making the greatest gains in these complex sites but narrowly missing the end of year plan position due to high volume sites such as breast and skin which are generally less challenging to restore and are more seasonally impacted.

In 2024-2025, we continued to focus on narrowing the gap between cancer and non-cancer clock stops for FDS, noting that when FDS performance is ranked for Cheshire and Merseyside for cancer diagnosed only, the system rose in the rankings by five places.

A comparison of treatment activity between the 12 months up to March 2025 and the previous 12-month period shows growth against all measures (Figure 6).

Figure 6 April 2024 - March 2025 vs April 2023 - March 2024 Treatment Activity Comparison in Cheshire and Merseyside

Measure	Value	Commentary
Volume of patients seen for the first time following an urgent GP referral for suspected cancer	100%	Data relate to patients registered with Cheshire and Merseyside GPs. Data are from Cancer Wait Times Dataset, most recent month March 25.
Cancer treatment activity: Volume of first definitive treatments for all diagnosed cancers	101%	
Cancer treatment activity: Volume of surgical treatments for all diagnosed cancers (all surgical treatments whether first or subsequent)	105%	
Systemic-Anti Cancer Therapies (SACT) (inc chemo) administrated at Clatterbridge Cancer Centre	104%	These data relate to April 24 - March 25 as a % of April 23 - March 24.
Radiotherapy (RT) planning volumes at Clatterbridge Cancer Centre	101%	

The NHS Long term Plan[1] includes the ambition that, by 2028, 75% of people with cancer will be diagnosed at an early stage (Stage I or Stage II) and that 55,000 more people will survive their cancer for five years or more. Cheshire and Merseyside made significant progress against these ambitions in 2024-2025.

Cancer Research UK[2] highlight that people from more deprived areas are more likely to be diagnosed with cancer via emergency presentation, compared to people from less deprived areas. People diagnosed with cancer via emergency presentation are more likely to be diagnosed at a late stage and, therefore, have poorer outcomes. More than a third of Cheshire and Merseyside's population live in the top 20% most deprived (Quintile 1) areas in England and are, therefore, statistically more likely to be diagnosed with cancer at a later stage.

It is also recognised that cancer incidence is higher in more deprived areas.[3] In real terms, this means that for the 890,000 people living in Quintile 1 areas of Cheshire and Merseyside, they are both more likely to develop cancer in their lifetime and more likely to be diagnosed at a later stage. By improving rates of early diagnosis in these areas, Cheshire and Merseyside Cancer Alliance can directly improve outcomes for people diagnosed with cancer, with earlier diagnosis linked to better survival rates.

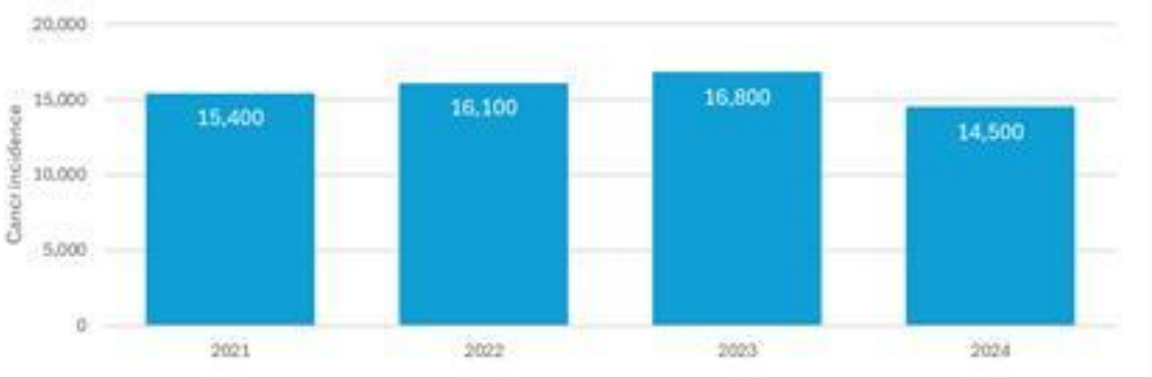
111,000 people in Cheshire and Merseyside are living with or beyond a diagnosis of cancer.[4] This means that, for every 1,000 people living in Cheshire and Merseyside, 44 will have experienced a diagnosis of cancer.

Approximately 17,000 new cancer diagnoses are recorded each year for Cheshire and Merseyside patients, within the Rapid Cancer Registrations Dataset (where 89%

[1] NHS England » NHS Long Term Plan ambitions for cancer
[2] Health inequalities: Improving early cancer diagnosis for everyone - Cancer Research UK - Cancer News
[3] There are higher rates of cancer in the most deprived areas - NHS England Digital
[4] Patients diagnosed with a malignant cancer (C00-C97 excluding C44) between 1995-2021 who were still alive on 31st December 2021 (CancerStats2 Cascade)

of all cancer diagnoses are captured within the dataset)[5]; the most up-to-date cancer registrations resource[6] (Figure 7).

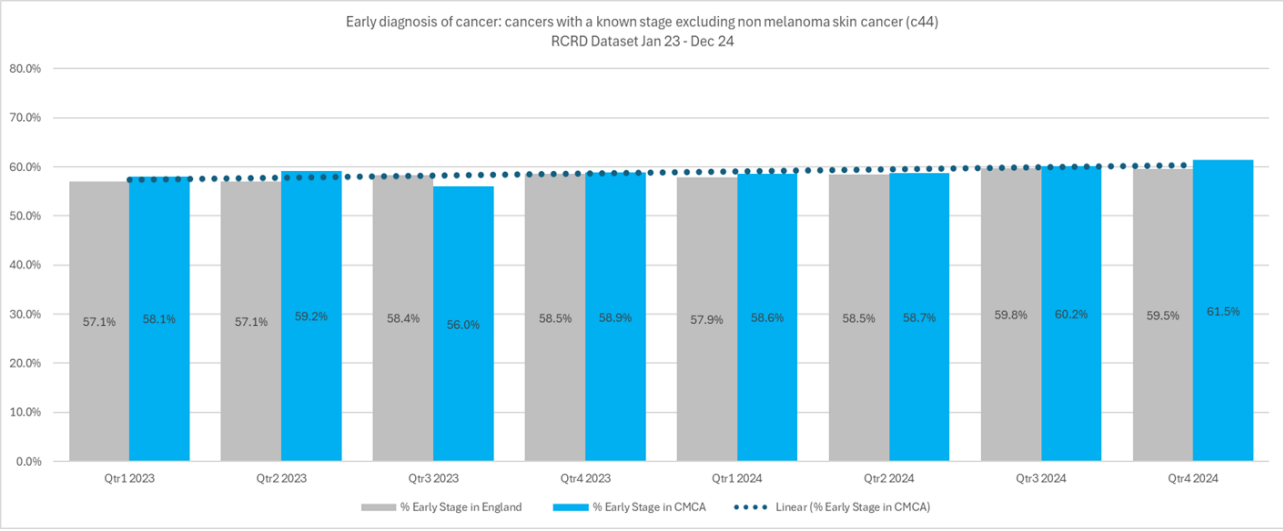
Figure 7 Cancer Incidence in Cheshire and Merseyside 2021 – 2024*



*Rapid cancer registration dataset: all cancers rounded to the nearest 100. Part year Sept 2024

Quarterly early diagnosis proportions have increased overall in the past two years. Overall, 58.9% of Cheshire and Merseyside cancers were diagnosed at an early stage in the last two years, this is statistically similar to England (58.4%)
Early diagnosis in Cheshire and Merseyside has increased from 58.1% in Quarter 1 2023 to 61.5% in Quarter 4 2024.

Figure 8 Proportion of RCRD cancers diagnosed at an early stage in Cheshire and Merseyside compared to England.



[5] RCRD incidence and treatment dashboard | CancerStats
[6] The Rapid Cancer Registrations Dataset (RCRD) is available up to September 2024 as of February 2025 and captures around 89% of cancer registrations (around 17,000 per year): RCRD uses and limitations publication (https://digital.nhs.uk/ndrs/data/data-sets/rcrd). 100% of cancer registrations are available in the Cancer Outcomes and Services Dataset (COSD), where the most recent data relate as of February 2025 relate to 2022.

Case Study – Cancer survival rates

People in Cheshire and Merseyside are surviving longer after a cancer diagnosis than ever before.

New statistics show that patients in the region are now surviving cancer for more than five years at a higher rate than the England average, despite more people in Cheshire and Merseyside developing the disease than in most areas of the country.

Over the last decade, this five-year index of cancer survival has increased by 7.8% for Cheshire and Merseyside, compared with 6.5% for England.

One of the factors behind this success is NHS Targeted Lung Health Checks, which use mobile scanning trucks to reach into local communities to test for lung cancer in those aged 55 to 74 who have a history of smoking.

Prioritising communities in which residents are statistically less likely to get tested, more than 560 cancers have been detected in Liverpool, St Helens, Halton, Knowsley, South Sefton Warrington and Wirral since 2019 – with around 80% of those discovered at an early, more treatable stage.

People diagnosed with lung cancer at the earliest stages are nearly 20 times more likely to survive for five years or more than those whose cancer is caught late.

1.2.3.4 Mental health

NHS Cheshire and Merseyside works to ensure that high-quality, timely mental health care is provided for everyone who needs it and aims to tackle inequalities in access, experience and outcomes. Significant progress has been made over the lifetime of the NHS Long Term Plan, however further work is required to fulfil all national ambitions.

During 2024-2025:

- NHS Cheshire and Merseyside significantly increased access to transformed **community mental health services** for adults and older adults with severe mental illness - exceeding the national ambition. Policies and practice in place for patients with serious mental illness were reviewed to identify key challenges and gaps for those who require intensive community treatment and follow-up but where engagement is a challenge. An action plan has been developed to address potential gaps in provision.

- **Early intervention in psychosis** services consistently exceeded the national ambition to ensure that people entering treatment wait less than two weeks. Identification and treatment at the onset of psychosis promotes recovery by reducing the probability of relapse and improves long-term outcomes for

individuals and their families.

- The number of **people with severe mental illness receiving a full annual physical health check** within the last 12 months fell 8% short of expected levels, based on Quarter 3 reporting. Historic trends indicate that an increase in Quarter 4 is often delivered, however, the pressures faced by primary care this year may pose a risk to all six of the health check components being delivered. Further work is being undertaken to identify whether there are any specific service or training need gaps at Primary Care Network level to ensure completion of all checks.

- The **dementia diagnosis rate** of 66.7% was consistently achieved throughout 2024-2025 following the introduction of new assessment pathways, work with primary care to identify people already diagnosed but not on GP registers and promotional work to encourage people to attend for an assessment.

- Data quality issues relating to the recording and reporting of **children and young people's eating disorder services** resulted in nationally published data not accurately reflecting local performance. Demand has increased following the COVID-19 pandemic, leading to capacity challenges and increased waiting times in some parts of the system. However, overall, 89% of routine referrals are seen within four weeks. Work is underway to review how pathways can be improved across community eating disorder teams to provide more effective and efficient care.

- Access to **children and young people's mental health services** remained static throughout the year with rates below target by c2,600 children and young people. A further five Mental Health Support Teams in schools were mobilised in Quarter 3 and will contribute to increased access as they develop. Informed by our work with children and young people, NHS Cheshire and Merseyside launched its Children and Young Peoples Mental Health Transformation Plan (2024-2026), which includes eight key objectives relating to care:
  - Inclusive
  - Timely access
  - 18-25 offer
  - Eating disorders
  - Crisis response
  - Appropriate places of care
  - Specialist mental health care
  - Innovative.

- **Perinatal mental health services** continued to exceed national trajectories ensuring that birthing people with moderate to severe mental health difficulties have access to specialist community care from pre-conception to 24 months after birth - with increased availability of evidence-based psychological therapies.

- **Talking therapy services** delivered good rates of reliable improvement and reliable recovery throughout 2024-2025, but did not achieve these new metrics every month. Access to talking therapies remained broadly static throughout the year with further workforce expansion required to achieve national ambitions.

Additional trainee therapists started in post in Quarters 3 and 4 with additional funding committed via the government's Autumn Statement for a five-year period. A single Cheshire and Merseyside Service Specification has been developed to ensure consistency of delivery based on good practice and a "readiness for therapy" video has been developed to increase reliable improvement and reliable recovery rates.

Case Study – Transforming children's mental health services, Wirral

NHS Cheshire and Merseyside's Wirral Place team was honoured as an Outstanding Commissioner in the NHS category at the Voluntary Sector North West Funding and Commissioning Awards 2024.

The award recognised Wirral's groundbreaking work to transform children's mental health services and innovative approach to commissioning, which prioritises collaboration, co-production and long-term sustainability.

These efforts led to the creation of Branch, an online mental wellbeing hub for children and young people, supported by a £750,000 annual investment for at least seven years.

Designed with input from young people, the hub represents a bold, forward-thinking model for delivering community mental health support at scale.

1.2.3.5 Learning disabilities

Working with NHS England, NHS Cheshire and Merseyside set out to reduce the number of inpatients, where appropriate, by the end of 2024 - 2025 to a maximum of 60 and to ensure that at least 75% of people with a learning disability received an annual health check.

To help achieve these aims, all Places across Cheshire and Merseyside have a Learning Disability Adult Intensive Support Function (ISF) to support people in the community when they are in crisis. A review of Intensive Support Function regarding adult services has taken place and adjustments made to ensure a standardised approach to service delivery. Opportunities to develop an Autism ISF provision for adults are being looked at by commissioners and providers to help reduce the number of people with Autism being admitted to general mental health wards.

Work is also underway across Cheshire and Merseyside to ensure the revised Dynamic Support Register and Care (Education) and Treatment Review policy is implemented in full, with a particular focus on out-of-area placements and adults with a diagnosis of autism only.

Table 5 summarises the position at March 2024 and the number of adult inpatients to achieve 10% and 20% reductions.

Table 5

Learning Disability & Learning Disability & Autism Adults					
	As at March 2024 (excluding S17)	**10% Reduction**	**20% Reduction**		**Dec 2024 inpatients as at Dec 2024 (excluding S17)**
NHS CHESHIRE AND MERSEYSIDE ICB **Learning Disability- Adults**	57	51	46		46
NHS CHESHIRE AND MERSEYSIDE ICB **Autistic Adults**	35	32	28		36

Case Study – Supporting children and young people with learning disabilities

A teenage boy won a national award for working with a Liverpool hospital to make visits as easy as possible for children with learning difficulties.

Lewis Wright, from Sefton, won the Child Hero award at the 2024 NHS England National SEND Awards for introducing sensory boxes to Alder Hey Children's Hospital.

Lewis, who has Autism, Sensory Processing Disorder and other health needs, worked with clinicians to walk through the children's hospital to see where the biggest sensory issues were for young people before coming up with the idea of sensory boxes.

Lewis' sensory boxes are filled with various materials like caps, sunglasses, fidget toys and ear defenders. Learning from Lewis' hospital walkthrough was shared with hospitals across Cheshire and Merseyside.

The Quarter 4 position shows that Cheshire and Merseyside is delivering more Annual Health Checks than at the same time last year - exceeding the target of 75% for 2024-2025 (Table 6).

To achieve this performance, the Transforming Care Programme supported fortnightly Cheshire and Merseyside system calls throughout 2024-25, to support patients who are clinically ready for discharge, alongside Mersey Care NHS Foundation Trust and Cheshire and Wirral Partnership NHS Foundation Trust colleagues.

Table 6 Annual Health Checks

Organisation	Completed Checks (YTD)	LD Register Size	% Completed	Health Checks Declined	Patients NOT had a check	Checks required to reach 75%*
NHS Cheshire & Merseyside	11,860	14,869	79,76%	997	2,012	Target reached
North West	34,890	42,529	82.04%	2,130	5,509	Target reached

A Housing Lead continues to solve accommodation issues which can lead to delayed discharges, and is meeting with North West Housing Lead and analysts to map those individuals clinically ready for discharge with housing difficulties, with a Cheshire and Merseyside Housing Strategy in development.

One of the biggest issues facing Cheshire and Merseyside relates to an increase in the number of people with either suspected autism or a diagnosis of autism being admitted to mental health beds. As many are not previously known to services, it is often difficult to find an alternative to admission. However, throughout 2024 - 2025, people with suspected autism or a diagnosis of autism who had been admitted to adult mental health wards with a primary mental health disorder were identified quickly and those who required escalation reviewed on system calls.

Separately, capital funding has been secured for a number initiatives to develop bespoke accommodation. The Transforming Care Programme has also invested in outreach workers, autism liaison workers in Community Mental Health Teams and autism hubs.

Case Study – Autism

A 48-year-old woman with autism who spent more than a decade in hospital in a secure setting is now back in her own home and being supported in the community.

In addition to autism and a mild learning disability, she also has Smith-Magenis Syndrome - a developmental disorder that affects behaviours, emotions and learning processes and can lead to self-injury.

Happily, she is now supported in the community by a care team including staff from Mersey Care NHS Foundation Trust and says she is delighted to feel ‘part of society’ again.

1.2.3.6 Community Services

In line with national guidance detailed within the Lord Darzi report to shift from "Hospital to Community" and from "Treatment to Prevention" there has been significant work to enhance Cheshire and Merseyside's community services offer in 2024-2025.

The nine providers of NHS community health services have worked in partnership through the Mental Health, Learning Disabilities and Community (MHLDC) Provider Collaborative to identify and share best practice. We have been particularly proud of the development of the community services data-set that now means that NHS Cheshire and Merseyside has live data on out of hospital services to help identify pressures across the system on a daily basis.

There has also been great progress in work to increase the availability of alternatives to hospital, including schemes such as Call-before Convey, Urgent Community Response and Virtual Wards which have enabled patients to receive hospital-standard care in their usual place of residence. Community providers have also benefitted from close collaboration on reducing the incidence of hospital admissions due to falls by developing community-based prevention and treatment options.

Virtual Wards
The utilisation of virtual wards across Cheshire and Merseyside improved significantly during 2024 - 2025, meaning many more patients now have the opportunity to be treated in their own homes under the clinical supervision of a hospital-based clinician.

First implemented in 2022, the virtual ward service launched with a limited scope of clinical conditions, which meant that not all patients who were appropriate for home-based care were eligible for the service.

The original model for virtual wards across NHS Cheshire and Merseyside also meant that there were multiple organisations responsible for the service, with greater clarity needed around roles and responsibilities.

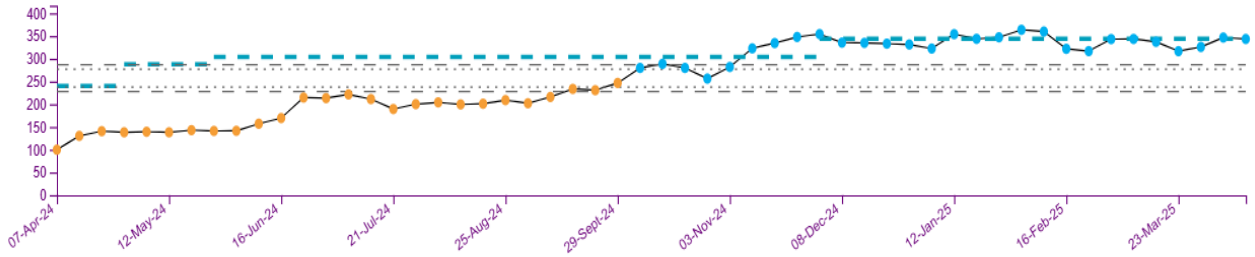
In January 2024, the responsibility for leading the virtual ward programme was devolved to Cheshire and Merseyside's Mental Health, Learning Disabilities and Community Services Provider Collaborative. At this time utilisation was around 50% of capacity.

The provider collaborative worked with each of the eight lead providers to develop new pathways, new models of care and a revised reporting structure. NHS Cheshire and Merseyside now has greater operational and clinical buy-in and a new dashboard which not only measures utilisation and capacity but also outcomes and impact.

The team have also developed a health economics model to assess the real terms financial cost of virtual wards compared to standard care, which demonstrates an average saving of £635 per patient. NHS Cheshire and Merseyside is now the best

performing ICB in the North West for virtual ward utilisation and the fourth best performing nationally with daily occupancy levels often exceeding 90% utilisation of available capacity. Figure 9 demonstrates the increase in the use of virtual wards during 2024-2025.

Figure 9 **Average Weekly Bed Occupancy against 80% Target at All Providers**



Case study – Hospital at Home / Virtual Wards

Patient testimony from 'Mrs H': "I was getting mum up out of bed and the next minute she said 'I don't feel right' and fell on the floor. We phoned 999 and they sent an ambulance out.

"The ambulance team arrived - and they were lovely. They said: 'We'll get the hospital at home frailty team in touch with you,' who called about an hour later and asked whether they could come out. They helped us put mum in bed, diagnosed her with pneumonia and gave her IV antibiotics at home.

"We found it much better to keep her at home. We didn't have to get taxis back and forth to the hospital and I think she got on a lot better at home. We had a direct number to ring in case she got worse, so felt happy.

"The team looked after her really well. We couldn't fault them at all. Everything they did was spot on."

Urgent Community Response

People in Cheshire and Merseyside also benefitted from ongoing improvements to the Urgent Community Response (UCR) services during 2024-2025. The Urgent Community Response service is a community-provided model of care that offers an alternative to attendance at A&E. Instead, a clinician from within the community attends a patient's normal place of residence within two hours to assess and treat appropriate conditions.

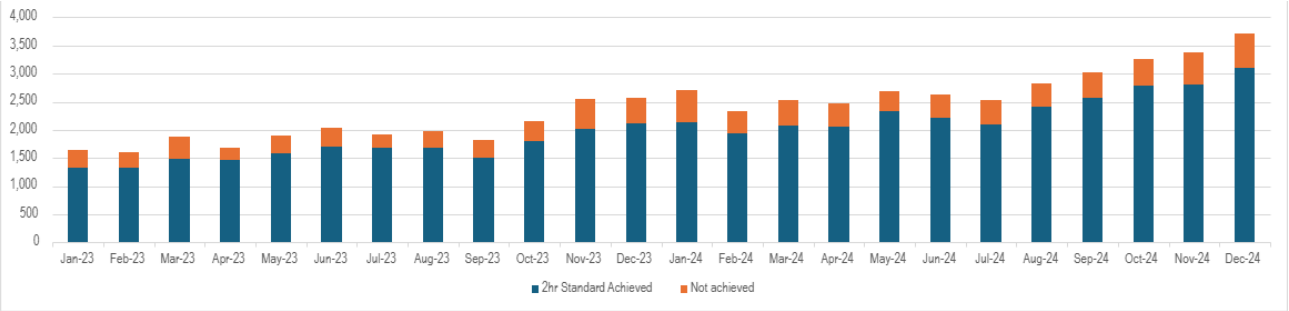
The number of accepted referrals into Urgent Community Response services has increased by 70% since the service began in 2023.

Collaborative work has meant that Cheshire and Merseyside has improved from accepting 2,400 referrals per month at the start of 2024-2025 to now more than 3,500. This increase has been supported via data packs for each Place and provider

and a detailed analysis of the further opportunity for Urgent Community Response services.

The chart below (Figure 10) demonstrates the steady increase in accepted referrals into the Urgent Community response service across all provider organisations and on aggregate.

Figure 10 Two-hour standard Urgent Community Response Referrals



Despite these improvements, there remains further opportunity for increased capacity in both Urgent Community Response and virtual ward services in 2025-2026. A proposal for a 15% increase in virtual ward capacity is being considered with an expectation that this would – in turn – help to reduce hospital bed occupancy and contribute to urgent care improvement targets. A review of Urgent Community Response services during 2025-2026 will look in detail at the capacity of existing services and develop further proposals.

Single point of access

Feeding into both the Urgent Community response and virtual wards services is a further new development – a "Call before Convey" model - which gives ambulance crews greater access to further clinical input from hospital and community-based doctors and nurses via a single point of access. This supports timely access to community services including home treatment teams, virtual wards and urgent community response teams.

Community waiting times

During 2024-2025 the number of patients waiting for a community services appointment has increased as NHS Cheshire and Merseyside develop the offer "from Hospital to Community" referenced in the 2024 Darzi report. While overall numbers have increased, the number of adult patients waiting more than 52 weeks has reduced significantly due to a review of the waiting lists, improvements to data quality and sharing of best practice procedures between provider organisations.

The number of adult patients recorded as waiting more than 52 weeks for community services reduced from 289 in April 2024 to just 164 in January 2025. The number of children and young people who have waited in excess of 52 weeks has not yet seen the same improvement and challenges continue to be experienced in increased referral rates - especially around services impacted by the COVID-19 pandemic.

1.2.3.7 Primary Care

General Practice

GP practices across Cheshire and Merseyside are now delivering more appointments – by all available means – than in 2023-2024, exceeding both the local and national targets.

More than 500,000 additional appointments were delivered across Cheshire and Merseyside in 2024-2025 than in the previous 12-month period. To put this into further context, GP practices across Cheshire and Merseyside now deliver more than 18% more primary care appointments per year than in 2019 – a rise from c13.1m to c15.6m appointments.

During 2024-2025, practices were supported to access the national **General Practice Improvement Programme**, funded by NHS England, which is currently in its second year - with 26 practices accessing this across four cohorts in 2024-2025.

Overall, Cheshire and Merseyside's general practice workforce has grown by a third since 2019. This reflects growth in direct patient care staff funded through the Additional Roles Reimbursement Scheme (ARRS).

Highlights from 2024-2025 across Cheshire and Merseyside's nine Places include:

- **Cheshire East -** all practices transitioned to cloud-based telephony systems with the support of the National Procurement Hub. Most have migrated to either X-On or CheckComm with one practice choosing to use C-Talk. These systems have advanced features such as call-back and call queuing functionality. This transition ensured improved communication efficiency and reduced waiting times for patients calling into practices.
- **Cheshire West** - agreed a range of metrics to measure improvement in access for patients across our practices - 91% (38) of practices achieved improvements.
- **Halton** - 100% have online registration available. This exceeded the national target of more than 90% of practices using the online registration system by December 2024.
- **Knowsley-** General Practices in Knowsley are providing more appointments than ever before. 821,261 appointments were booked between 1st April 2024 and 31st January 2025 compared to 754,091 for the corresponding period in 2023 - 2024. Since April 2024 each of the 23 GP practices in Knowsley have utilised a cloud-based telephony system, all practices offer a 'callback facility' to patients who contacting the practice by phone but are entered into a queue for a call handler and have also put in place messaging software to support patients to communicate with practice via secure SMS messaging. This supports two-way communication between patient and practice.
- **Liverpool** - Total number of appointments increased from a monthly average of 191,853 in 2023 to 194,190 in 2024. The percentage of appointments delivered within 14 days over the last 12 months was 92%, exceeding the stated Integrated Care System ambition.

- **Sefton** - an Acute Visiting Scheme supported access and provided benefit to the wider system. The Acute Respiratory Infection hub in South Sefton was also maintained.
- **St Helens** - Urgent Care Hubs are being developed to support general practice and will also benefit the wider system, in particular A&E. One Primary Care Network has successfully piloted the Hub and plans are being developed to mainstream to other Primary Care Networks.
- All five Primary Care Networks in **Warrington** engaged in and followed the National Association of Primary Care framework. Ongoing Schemes for new developments and repurposing existing estates for primary care will lead to an increase in the physical space available to primary care to accommodate the increased workforce.
- **Wirral** - is above the national average of 432 appointments provided per 1,000 population and averages c194,000 appointments per month with an average of 486 appointments per 1,000 patients – the highest in Cheshire and Merseyside. Wirral offers 83.02 GP Full Time Equivalents (FTE) per 1,000 population which is also the highest in Cheshire and Merseyside and one of the highest nationally.

Case Study – General Practice Awards 2024

Primary care teams from Cheshire and Merseyside won four categories and were highly commended in another at the national General Practice Awards 2024.

Cheshire and Merseyside nominees took home four awards – more than any other region in the country.

South Sefton Primary Care Network won Primary Care Network of the Year for significantly improving access for patients – adding more than 20,000 additional minor illness appointments per year via its South Sefton Access Service. Its work to streamline mental health referrals, consolidating 14 referral routes into one, is also helping to reduce inappropriate referrals and improve patient safety.

The Liverpool Homeless Palliative Care Multidisciplinary Team – formed by the Brownlow Health Homeless Team and Marie Curie Hospice in Liverpool – won General Practice Team of the Year. The collaboration works to ensure that every patient experiencing homelessness is supported as they reach the end of their life, in the place of their choosing, with those that matter most to them.

The nursing team at Brownlow Health in Liverpool won Nursing Team of the Year for successfully developing a range of new and innovative roles including homeless in-reach nurses and a nurse-led frailty team.

Anfield and Everton Primary Care Network's Community Innovation Team won the Clinical Improvement – Public Health and Prevention category for their 'Be Breast Savvy' campaign to encourage the benefits of breast cancer screening.

Dental Services

NHS Cheshire and Merseyside developed an ambitious two-year Dental Improvement Plan in 2024 to help tackle some of the challenges facing NHS dental care.

Building on national reforms, the plan is aimed at increasing access to both routine and urgent NHS dental care and improving oral health in the local population - backed by an extra £15m of local funding to support the plan's delivery.

Working in close partnership with local professional networks such as the Local Dental Network, Local Dental Committees and NHS England's North West Dental Public Health team, the plan was also closely informed by feedback from Healthwatch, local authorities and other key stakeholders.

Two main areas of focus for this work have been:

- incentivising contracts for providers of NHS Dentistry to encourage them to increase capacity for NHS patients
- offering additional incentives to providers for supporting vulnerable patient groups

155 dental practices across Cheshire and Merseyside signed up for the New Patient Premium (nationally funded) to help treat patients who haven't been seen by a dentist for more than two years. Between April and December 2024 work by practices resulted in the delivery of more than 70,000 additional patient appointments across the region – including 28,367 children, and 45,883 adults.

A new network of dental practices was agreed in June 2023 to provide urgent care appointments for patients who are unable to access regular care – including via the Emergency Dental Helpline (0161 476 9651). Between April and December 2024, these practices saw 12,375 additional patients for urgent care treatment.

Across Cheshire and Merseyside, 76 dental practices also signed up to deliver 'Urgent Care Plus' – a scheme which offers additional funded sessions as an extension to the urgent care pathway. This scheme enables patients who have attended an urgent care appointment to also receive a full examination, and any further treatment required to help get them dentally fit again. A total of 9,679 patients were seen via this route between April and December 2024.

Another project which has been developed locally aims to help improve access to new patients within the Cheshire and Merseyside boundaries, with a focus on supporting vulnerable patients by offering an incentive for practices to engage with local voluntary sector organisations, such as homeless centres and family hubs. 53 local dental practices signed up to the scheme and data from 42 of these practices showed that more than 21,000 new patients had been seen via this route to date.

In order to address workforce challenges NHS Cheshire and Merseyside has also been looking to address some of the longer-term workforce challenges in NHS dentistry, and launched a recruitment incentive scheme to help tackle local dental workforce issues in more deprived areas, including areas of Liverpool and Knowsley.

Case Study – Developing a new dental model

A new 'proof of concept' service has been piloted at a vacant practice in the Belle Vale area of Liverpool, which is close to the Knowsley boundary and in an area of high need.

The service offers dental sessions focused solely on patient outcomes, rather than measured in strict units of dental activity against a set target - supporting better access to dental care for vulnerable patient groups.

More than 4,000 patients have been referred to this service to date, including children, nursing and expectant mothers, patients referred from other hospital and social care settings and asylum seekers.

The project is proving very popular with staff as they are supported to focus on achieving better outcomes for patients who have previously struggled to access dental services. This supports the retention of NHS dentists and, in some cases, the flexibility offered has encouraged dentists who provide private work to switch to providing sessions for the NHS.

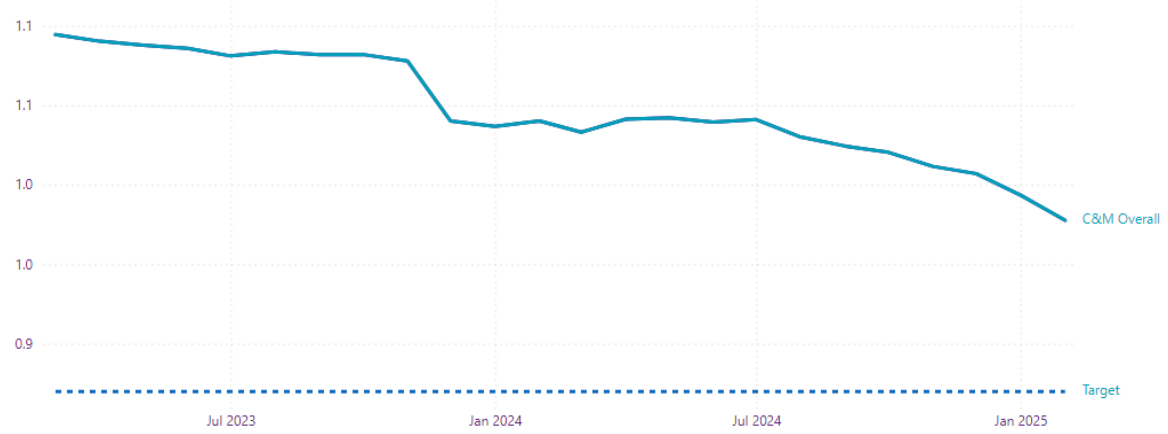
Medicines and Prescribing

NHS Cheshire and Merseyside's objectives for 2024-2025 with regards appropriate Infection Prevention and control processes and Anti-microbial Stewardship were to:

- use data to improve reporting and deliver quality improvements in infection prevention and control and antimicrobial resistance.
- implement national hydration pilot for Cheshire and Merseyside and spread learning across the North West and nationally.
- implement the five-year national action plan for antimicrobial resistance to optimise use – for example by reducing the prescribing course length and prescribing rates for children.
- promote increased uptake of vaccinations across Cheshire and Merseyside to help prevent infection.
- develop a public-facing campaign to raise awareness around antimicrobial resistance in children and the importance of hydration.

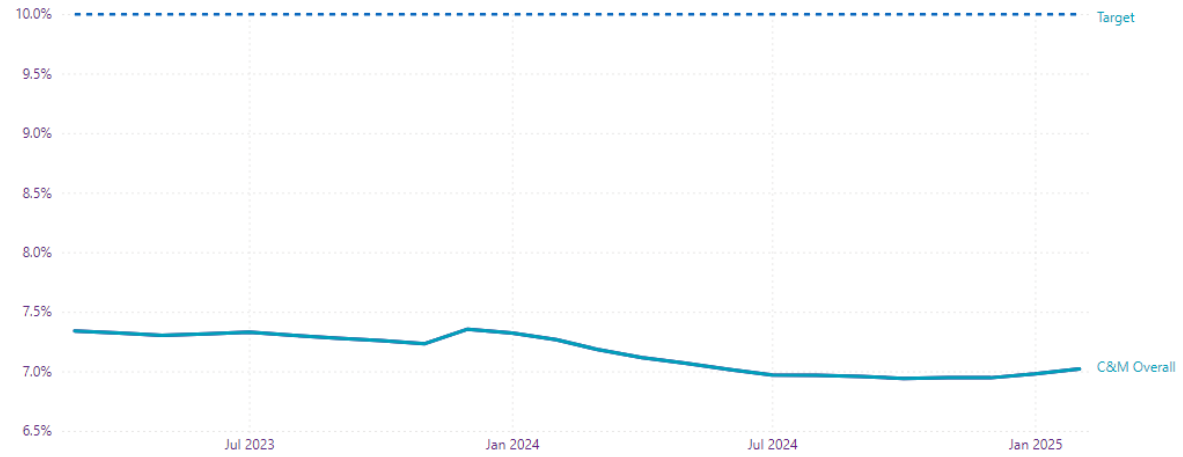
With regard to antibiotic prescribing, the trend for Cheshire and Merseyside is promising as our total volume of antibiotics issued from primary care continues to reduce.
Using the latest available prescribing data for February 2025 Figure 11 illustrates the prescribing of antibiotic per STAR-PU (or Specific Therapeutic group Age-sex Related Prescribing Unit) is 0.98 against a national target of <0.861 antibiotic per STAR-PU.

Figure 11 Antibiotic items per STAR-PU – Cheshire and Merseyside



The latest available data for assessing performance of prescribing of restricted antibiotics across Cheshire and Merseyside continues to show a good performance against this marker with Cheshire and Merseyside comfortably attaining the target of <10% as shown in Figure 12.

Figure 12 Proportion of Co-amoxiclav, cephalosporins and quinolones



A focused piece of work across Cheshire and Merseyside prioritised the review of patients who are prescribed longer courses of antibiotics for recurrent urinary tract infections - which has seen many patients who had been prescribed antibiotics inappropriately have these courses stopped. Prescribing of repeat antibiotics for recurrent Urinary Tract Infections was a focused piece of work during 2024/25 as Methenamine was introduced into the Cheshire and Merseyside Prescribing Formulary as a non-antibiotic treatment for Urinary Tract Infections, the aspiration here is improved long term management of this condition and improved patient outcomes by reducing the number of antibiotic courses required. The biggest area of success across Cheshire and Merseyside has been the joint effort to reduce antibiotic courses were appropriate from 7 days to 5 days for amoxicillin and doxycycline.

Case Study – Super Bodies: antibiotics reduction communications campaign

The NHS Cheshire and Merseyside communications team developed a creative behaviour change communications campaign – 'Super Bodies' – which ran throughout winter 2024-2025.

In response to Cheshire and Merseyside's high levels of prescribing of antibiotics in young children, the campaign was aimed at:

- Reducing overuse of unnecessary antibiotics for common illnesses in children
- Educating parents / carers on when to care for children with common conditions at home and how to spot the signs of a more serious illness
- Signposting parents and carers to the right service for their child's symptoms

Developed and delivered in-house, the campaign led with a positive message – promoting greater confidence in children's immune systems, and instilling confidence in parents' ability to seek the right help for their child. The campaign's creative concept features images of children 'superheroes', bright colours and energetic imagery, with a campaign strapline: 'I've got a super body'.

Optimised both organically and via digital and 'out of home' channels to boost reach of the message in areas of most need, the campaign secured an estimated 865,000 views in winter 2024-25 and was promoted by dozens of health and care partners across the system.

Following significant interest from regional and national colleagues, the campaign was subsequently rolled out nationally by Integrated Care Boards up and down the country.

Reviewing antibiotic prescribing data monthly has been key to the success we have seen across Cheshire and Merseyside, with a dedicated Antibiotic Prescribing dashboard on our Business Intelligence Portal, antibiotic guardians across Cheshire and Merseyside are able to track their own performance down to practice level, which has been key to identify areas of good practice and areas of concern across all Places to share learning and avoid duplication of audit protocols.

System working has been key when identifying pathways across the primary care and secondary interface to support effective de-labelling of penicillin allergy patients, the joint Cheshire and Merseyside AMR Working Group has been key in identifying and taking step to deliver these improvements to patient care.

The use of the RCGP TARGET Toolkit remains a priority in all Place based AMR action plans and increased awareness and communications around appropriate antibiotic prescribing during World AMR Awareness Week 2024.

As described in the case study below, the Super Bodies campaign has been a campaign programme and used across Cheshire and Merseyside to encourage appropriate self-care of common childhood illnesses including cough sore throat and ear pain.

Community Pharmacy

Launched in January 2024, Pharmacy First has enabled community pharmacies to complete episodes of care for seven common conditions following defined clinical pathways.

Building on the NHS Community Pharmacist Consultation Service, which has been running since October 2019, the service enables patients to be referred into community pharmacy for a minor illness or urgent repeat medicine supply, which – in turn – frees up GP appointments for patients who need them most.

526 pharmacies opted in to provide the Pharmacy First Service across Cheshire and Merseyside – that's 96.7% of all pharmacies in our region. The following tables show the overall performance of the NHS Cheshire and Merseyside Pharmacy First service.

Figure 13 Pharmacy First Consultation per 100,000

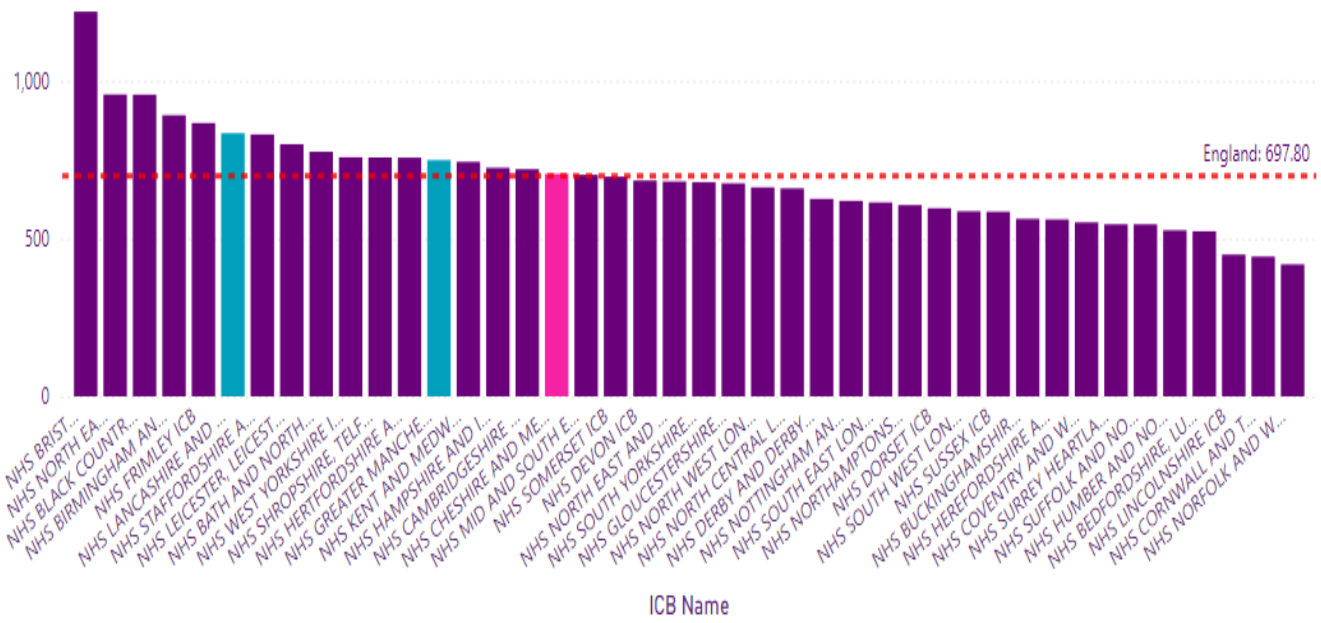


Figure 14 Pharmacy First Consultations in Cheshire and Merseyside

Pathway	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Total
Clinical pathways consultation	0	220	8,301	8,555	7,970	8,734	8,568	9,517	8,581	8,981	8,905	10,448	12,286	10,626	111,692
Minor illness referral	3,430	3,434	5,359	4,662	3,843	3,782	3,526	3,405	2,527	2,695	3,427	3,369	3,694	3,176	50,329
Urgent medicine supply	6,248	4,563	4,454	6,298	5,701	6,861	5,579	7,453	7,660	6,585	6,406	6,754	7,195	5,958	87,715
Total	**9,678**	**8,217**	**18,114**	**19,515**	**17,514**	**19,377**	**17,673**	**20,375**	**18,768**	**18,261**	**18,738**	**20,571**	**23,175**	**19,760**	**249,736**

Community Pharmacy Services and the dispensing elements of Dispensing Doctors contracts are managed through NHS regulatory mechanisms. In order to manage and implement these regulations, NHS England established local committees to be known as Pharmaceutical Services Regulations Committees (PSRC). Via this mechanism, NHS England delegated decision-making to ICBs in relation to matters including:

- Market Entry / Exit applications for Community Pharmacy and Dispensing Doctors,
- contractual matters for consideration e.g. amendment to opening hours, consideration of Breach or Remedial notices for breaches in contractual Terms of Service
- Fitness to Practice applications pertaining to Superintendent Pharmacists or Directors of companies providing pharmaceutical Services
- Upkeep of the published Pharmaceutical List. (list of all pharmacies and dispensing doctors in each Health and Wellbeing Board Area)

NHS Cheshire and Merseyside maintains a Pharmaceutical Services Regulations Committee that meets monthly in order to discharge its delegated responsibilities. The Committee Terms of Reference can be found on the ICB website at: https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/.

Where appropriate, decisions are taken with regard to the Pharmaceutical Needs Assessments. These are published by each Health and Wellbeing Board every three years with regard to the Joint Strategic Needs Assessments and determine the requirements for Pharmaceutical Services in each Health and Wellbeing Boards area.

Ophthalmology

Service provision for general ophthalmic services remained steady during 2024-2025. In addition, bespoke projects aimed at addressing inequalities in access to services for homeless patients, traveller sites and patients with learning disabilities continued.

A national workstream to deliver cardiovascular disease checks in optometry locations was launched. NHS Cheshire and Merseyside was also successful in a bid for £60,000 funding for provision and resource. An NHS Cheshire and Merseyside-funded Optometry Workforce Development Project, working with key stakeholders continued into 2024-2025.

1.2.3.8 Integrated Care

Joining up care leads to better outcomes. When local partners – the NHS, councils, voluntary sector and others – work together, they create better services based on local need.

Better Care Fund

Introduced in 2015, the Better Care Fund programme spans both the NHS and local government. It supports the joining up of health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

The Better Care Fund requires ICBs and Local Authorities to jointly plan and fund services to achieve these ambitions. NHS Cheshire and Merseyside and its nine local authority partners set Place-level plans and targets, with impact measured through a range of national measures. A key area where the Better Care Fund has been used across all nine Places is in relation to falls.

Cheshire and Merseyside has a relatively high rate of falls which result in a hospital admission. However, during 2024-2025 there was a reduction in falls related hospital admissions across all nine Places. This was achieved through Place-based falls prevention work - including proactive care and case finding, online tools, expanded telemedicine across care homes and by supporting local care homes around alternatives to admission following a fall. As an example, in Liverpool, this has led to a 5.5% reduction in falls admissions.

There have also been improvements in provision and access to services that prevent avoidable admissions following a fall, including improved utilisation of urgent community response services, enhanced falls pick up and falls response services - enabling more people to remain at home following a fall, where appropriate.

NHS Cheshire and Merseyside is a core partner in the Cheshire and Merseyside Falls Collaborative which brings together NHS, adult social care, public health and other partners from across our footprint to identify, plan and oversee the implementation of activities to reduce falls.

Case Study – Falls prevention, Cheshire West

Health and care partners in Cheshire West share a commitment to work together to prevent and reduce the number of people falling and sustaining serious injuries.

This work includes voluntary and community sector organisations, social enterprise grants and other public services, including Cheshire Fire and Rescue Service and North West Ambulance Service (NWAS).

As part of this work, NHS Cheshire and Merseyside has invested in 'Raisers' which allow people who have sustained a fall to be lifted off the ground by one person. Raisers are being utilised by Care Community Teams, the Urgent Community Response Service and Care Homes.

This has had a positive impact on NHS Services as it has reduced the number of patients being conveyed to hospital and reduced the incidents of serious harm, reduced admissions and thereby helped to improve health outcomes through prevention - particularly for older people who are at greater risk of falls.

Place-Based Partnerships

Each of the nine Places across Cheshire and Merseyside has a Place-Based Partnership, responsible for the design and delivery of integrated services in that Place. They involve a range of people interested in improving health and care, including the NHS, local councils, the voluntary, community and social enterprise sector and other local organisations, working alongside local people. More details about each of our Places can be found on the ICB website at: https://www.cheshireandmerseyside.nhs.uk/your-place/.

Place-Based integration programmes during 2024-2025 encompassed a wide range of programme areas, including urgent and emergency care; primary care and wider community services; mental health and learning disabilities; special educational needs and disabilities, as well as integrated neighbourhood working. There were also programmes that focused on the specific needs of different cohorts of patients, including children and young people, those with multiple health and social issues, and the frail and vulnerable.

In Knowsley, for example, a Hospital Discharge Settling in Service was introduced to support patients back home after spending time in hospital. The service provides non-medical short-term support both for people who have recently been discharged from hospital and those deemed at risk of admission. The service is now receiving on average 30 referrals per month.

A number of Places and their partners are progressing plans to identify and commission services to meet the health, care and housing needs for patients with complex mental health and learning disability issues. As part of its work on mental health inpatient bed capacity and flow, NHS Cheshire and Merseyside's Sefton team has commissioned an integrated mental health recovery service which provides 11 beds and two emergency respite beds to support

timely discharge and prevent hospital admission. There is also work underway with Sefton's Housing Department and their Housing Options Team to further develop pathways which support capacity and flow.

In Warrington, a Complex Needs Hub has been established to meet the needs of some of its most complex and vulnerable children and young people. NHS Cheshire and Merseyside, Warrington Borough Council and Mersey Care NHS Foundation Trust worked in collaboration and with wider stakeholders including service users to develop a local model and provision that seeks to maintain children and young people in their homes and communities and prevent avoidable entrants to care, custody, and admissions to inpatient acute and mental health settings. This new integrated and multi-disciplinary offer will provide a combination of community outreach and access to a local short stay residential offer.

Halton's Same Day Primary Care programme has brought together Halton's 14 GP practices and two Urgent Treatment Centres (UTC) to implement a consistent approach to same day care on a neighbourhood footprint – improving access to planned and on-the-day services through increased efficiency and allocation of resources. Cross organisational booking between practices and Urgent Treatment Centres is being piloted and pathways have been implemented for practices to refer into a high intensity users service.

St Helens progressed the implementation of their Care Communities in 2024-2025. Whilst Primary Care Networks remain at the heart of the care community and are taking a lead role in their development, care communities also include community, mental health, third sector and social care. Each Care Community is focussing on issues and opportunities relevant to its patients. As such, varying focuses include work to support children who are unable to attend school as a result of health issues, either personally or family issues; people known to multiple services from our most deprived communities and would benefit from a wide multi-disciplinary approach to their health and care; an Urgent Care hub; and proactive care for people with multiple long-term conditions.

In Cheshire East, the Nantwich and Rural Care Community developed a performance dashboard with key metrics for urgent and emergency care in 2024-25. These were used to better understand what was impacting upon the local urgent care system and to develop stronger accountability for performance.

In Cheshire West, a collaboration between Neston / Willaston Community Partnership, Cheshire Community Action and Wirral Age UK is working across the 'border' for patients admitted from Neston / Willaston into Wirral University Hospital to reduce delayed discharges. This has included an expansion of the Community Home First service to enable faster discharge for those who need additional support but, equally importantly, is providing opportunity to connect individuals into ongoing voluntary sector support such as befriending services.

NHS Cheshire and Merseyside, alongside other NHS partners at Place, have been working with our local authorities to prepare for and participate in Care Quality Commission (CQC) inspections of local authority adult social care services that have taken place during 2024-2025. These inspections have provided an opportunity to

further strengthen local relationships, showcase the benefits and identify further opportunities to improve the lives of our patients who also receive adult social care services through Place-based integrated working. During 2024-2025 the following Local Authorities have had their CQC inspections undertaken on adult social care services with the following overall assessment published (Table 7).

Table 7

Local Authority Area	Overall Rating
Cheshire East	Good
St Helens	Good
Warrington	Requires Improvement
Wirral	Requires Improvement

NHS Cheshire and Merseyside continues to be at the heart of Place-based Special Educational Needs and Disabilities Local Area Partnerships as they drive forward improvements in local SEND arrangements for our children and young people with SEND.

Case Study - Warm Homes for Young Lungs, St Helens

Health and Care partners across St Helens are working together to support those most at risk of hospital admission from respiratory conditions. One of the key focuses is to support young children who are users of salbutamol inhalers to not only manage their health condition, but to understand whether their living conditions – such as exposure to damp and mould – could be a contributing factor.

If it is considered that their living conditions may be worsening their condition, the child and their family are referred to other services who may be able to support them, such as:

- Healthy Air for Healthy Lungs Team, who manage indoor air quality
- Smoke Free Team, who can support family members to stop smoking
- Social prescribers, who can help the family get social support they need
- They may be supported to apply for grants for new boilers
- Voluntary Sector organisations such as Breathe Buddies, who help children and their parents manage how to most effectively use their inhalers.

This proactive approach has resulted in fewer hospital admissions for the children seen, more appropriate prescribing and referral to the right service where there could be an alternative cause for the condition.

In 2025-2026 the service will be further localised – offering a mix of appointments and drop-in sessions in community locations, such as Family Hubs.

1.2.3.9 Health Inequalities and Improvement

Health inequalities are systematic, unfair and avoidable differences in health across the population and between different groups within society. They arise because of differences in the conditions in which we are born, grow, live, work and age. These conditions influence how we think, feel and act and can affect both our physical and mental health and wellbeing.

In Cheshire and Merseyside, there are 2.7 million people living across areas of both significant wealth and substantial deprivation. We know that 36% (1 million people) of our population live in the 20% most deprived neighbourhoods in the country and 26% of our children (0-15 years) live in poverty.

Figure 15 shows the breakdown of the Cheshire and Merseyside population by deprivation quintile with the highest number of people living in quintile one (most deprived).

Figure 16 shows the index of multiple deprivation score by Lower Super Output Areas across Cheshire and Merseyside, with the darker areas indicating higher scores (more deprived) and the lighter areas indicate lower IMD scores (less deprived). The map clearly identifies high levels of deprivation across the Merseyside area with smaller areas of high deprivation in areas of Cheshire, such as Crewe.

Figure 15 Cheshire and Merseyside population by deprivation quintile

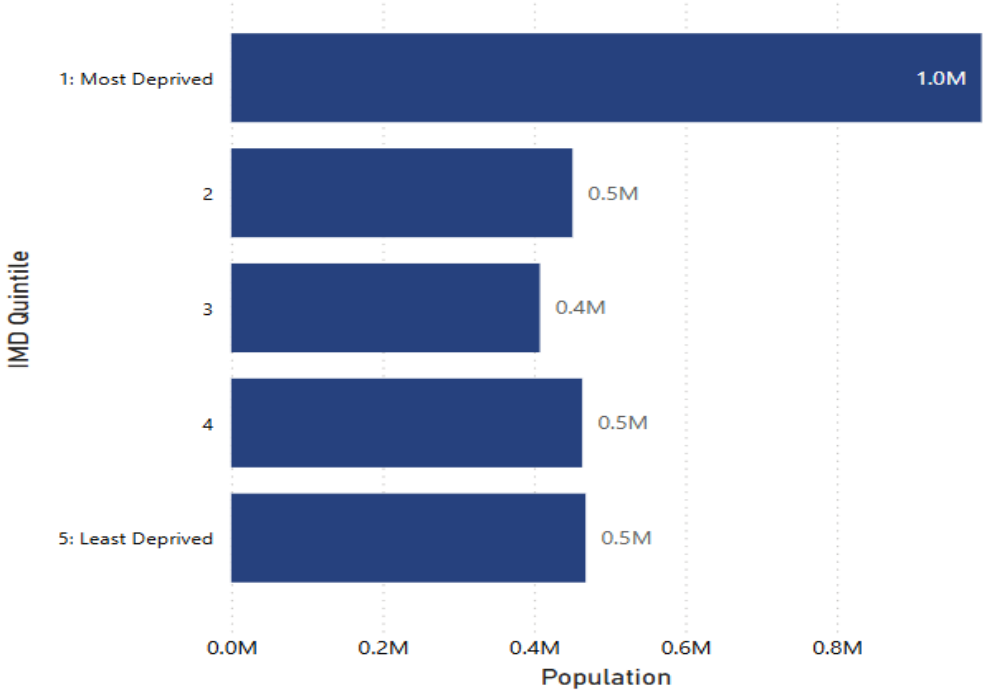
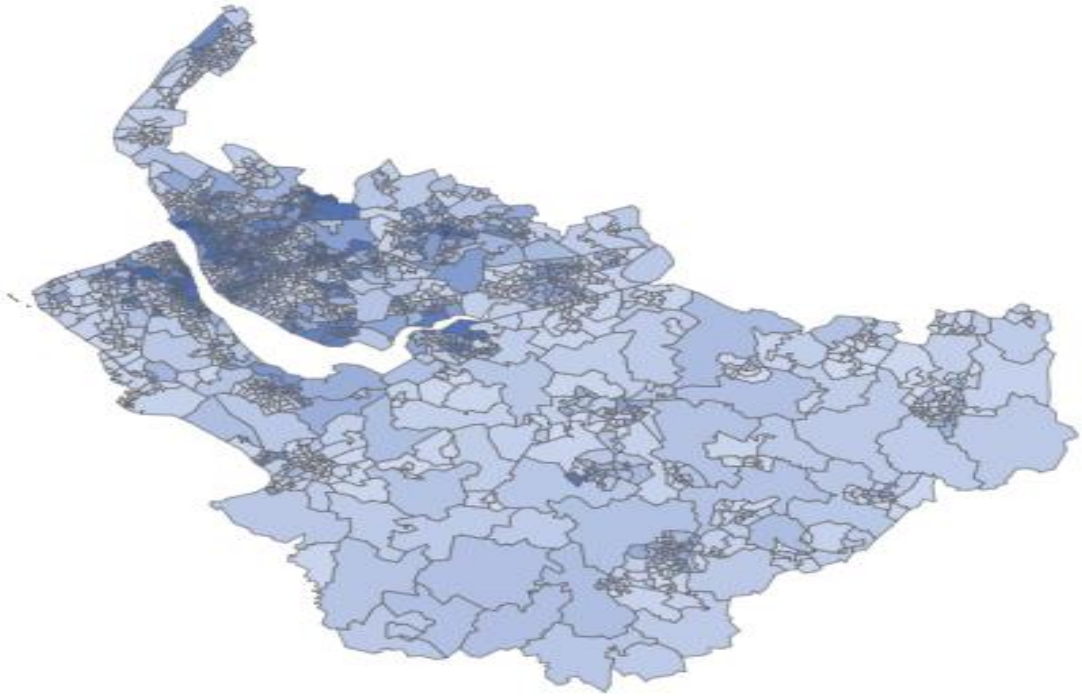


Figure 16 Index of multiple by deprivation score by LSOA



There is a strong relationship between deprivation and health outcomes. We know that those living in our most deprived communities have poorer health outcomes compared to our least deprived communities. This is clearly demonstrated in Figure 17 and Figure 18 demonstrating life expectancy at birth for males and females across each local authority area.

The darker shading indicates higher life expectancy, and the lighter shading indicates lower life expectancy. For women across Cheshire and Merseyside life expectancy is highest in Cheshire East at 83.8 years and lowest in Knowsley at 79.8 years. For men across Cheshire and Merseyside life expectancy is highest in Cheshire East 80.3 years and lowest in Liverpool 76.1 years. The areas with lower life expectancy are clearly the areas identified in map one as having high levels of deprivation.

Figure 17 Female life expectancy at birth in Cheshire and Merseyside 2018-2020

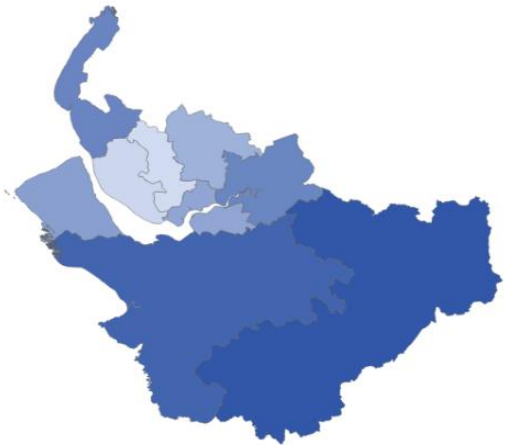
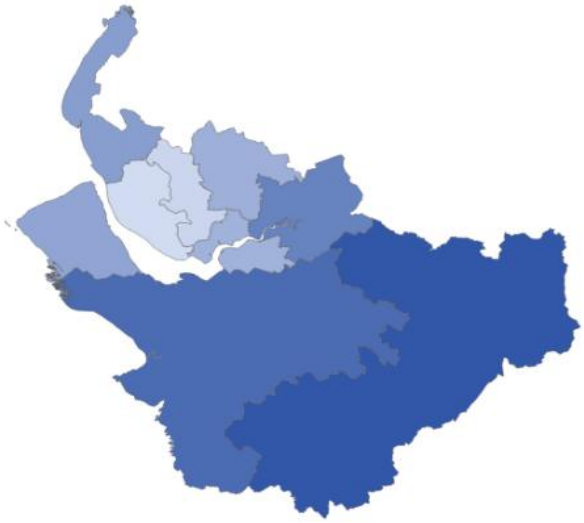


Figure 18 **Male life expectancy at birth in Cheshire and Merseyside 2018-2020**



Tackling health inequalities across protected characteristic groups, socio-economic status and health inclusion groups is a key priority of NHS Cheshire and Merseyside. The responsibility for reducing these health inequalities is delivered through distributed leadership across the key programmes of work included in this annual report.

Health Inequalities performance metrics are a key focus of the NHS Cheshire and Merseyside Board and include action to prevent cardiovascular disease and smoking.

As well as reporting on performance against these indicators, NHS Cheshire and Merseyside has created an appendix report on the NHS England indicators. NHS bodies are required to collect, analyse and publish this as part of their duty under section 13SA of the National Health Service Act 2006. This report details the action that we are taking against each of the 23 indicators across 11 domains:

- Elective Recovery
- Urgent and emergency care
- Respiratory
- Mental Health
- Cancer
- Cardiovascular disease
- Diabetes
- Smoking
- Oral health
- Learning disability and autistic people
- Maternity and neonatal.

Cardiovascular Disease (CVD)

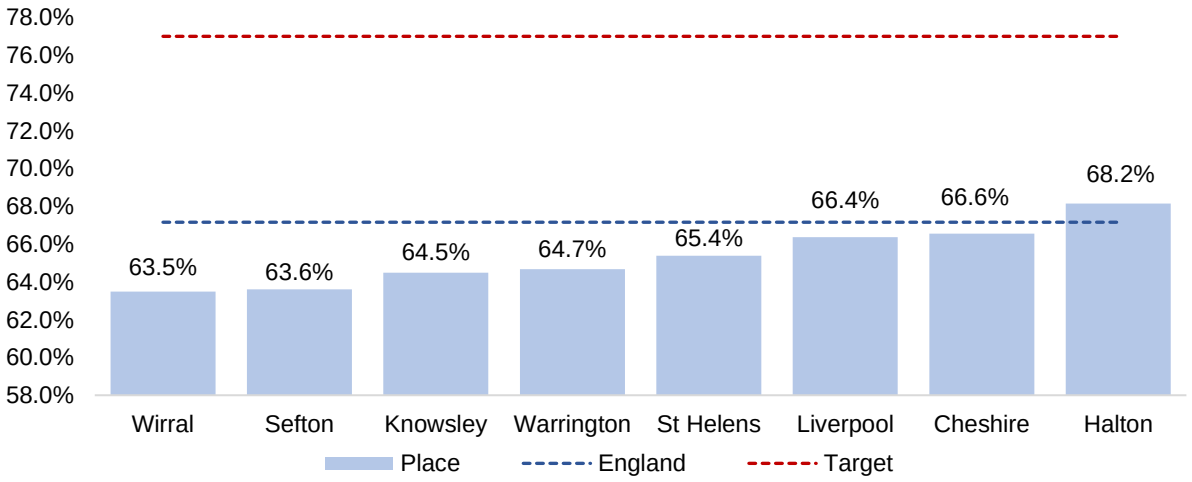
Cardiovascular Disease is the biggest contributor to the gap in life expectancy in the North West and a leading cause of premature death and health inequalities in Cheshire and Merseyside. It is associated with deeply embedded inequalities, with those in the most deprived 10% of the population

twice as likely to die as a result of Cardiovascular Disease than those in the least deprived 10%.

A person has high risk of Cardiovascular Disease if they have atrial fibrillation (AF), high blood pressure (B: hypertension) or high cholesterol (C). Early detection and treatment of these high-risk conditions reduces illness and improves quality of life. In Cheshire and Merseyside, it is estimated that improved blood pressure control alone could prevent around 1,500 additional heart attacks and strokes over the next three years.

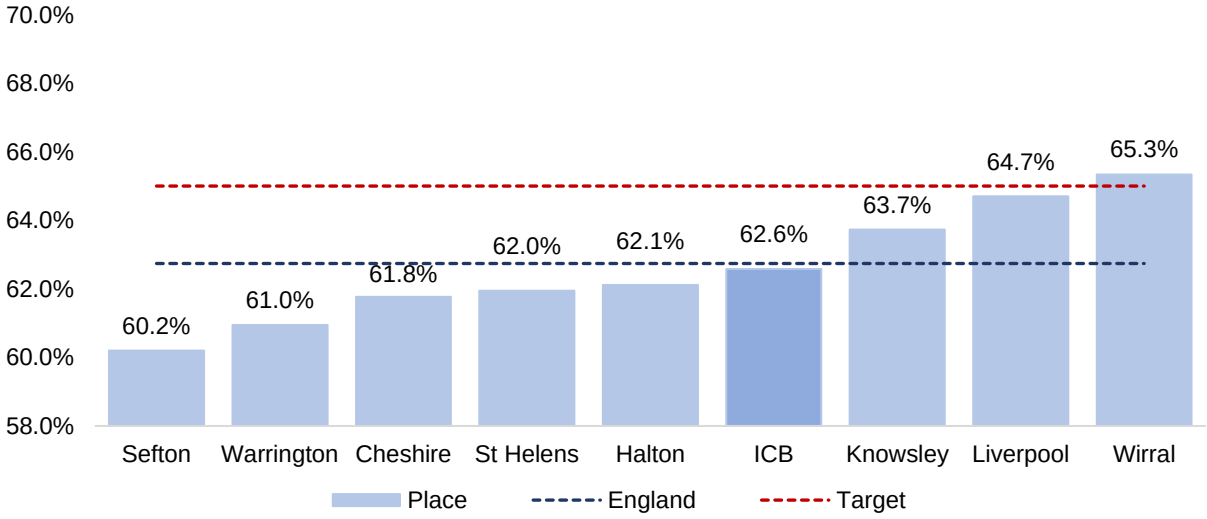
Current performance

Figure 19 **Percentage of patients (18+), with GP recorded hypertension, BP below appropriate treatment threshold**



None of Cheshire and Merseyside's nine Places are currently achieving the target of 77% of patients with recorded hypertension to have a blood pressure below the appropriate treatment threshold.

Figure 20 **Percentage of patients identified as having 20% or greater 10-year risk of developing CVD are treated with lipid lowering therapies**



Action undertaken in 2024-2025 to deliver improvements in performance

- **Blood pressure optimisation project** working with GP practices in some of the most deprived communities to reduce inequalities in access to blood pressure monitoring. This project is funded via national Health Inequalities / CVD Prevention funding.
- **CVD Prevention service** funded by NHS Cheshire and Merseyside this service receives referrals from the Targeted Lung Health Check (TLHC) programme. Targeted Lung Health Check scans often identify other health conditions – in addition to lung conditions - with the most common being coronary artery calcification. Those patients without a history of CVD are referred into the CVD Prevention Service for specialist assessment and a management plan.

Case Study – CVD Prevention Service

Below is the story of a patient who was referred to the CVD prevention service following a lung health check.

"At the appointment, we spoke about the different ways lifestyle can affect your health. We spoke about what changes could be made and why that would benefit me. I was offered a referral to the St Helens wellbeing service.

"The staff at both the CVD Prevention Service and wellbeing service were very supportive. I've had a couple of telephone consultations with them and they're helping me to feel better about myself and stay on the right track for a healthier diet. That little phone call give that positive reassurance I need.

"I plan to continue with the healthier changes I've made. I now have more awareness about lifestyle factors and why I need to keep applying them and to never give up.

"I feel I am very supported around my wellbeing, and I feel that is helping me make those healthier decisions like eating better and being more active. Making more positive choices. I feel very grateful."

- **CLEAR CVD Prevention programme** is a national programme designed to transform CVD preventative care in the community. NHS Cheshire and Merseyside has been successful in securing national funding for up to 16 Primary Care Networks to participate in this evidence-based model which offers sustainable and improved care.
- **Familial hypercholesterolaemia (FH) genetic testing service** has been recurrently funded from 2024-25 by NHS Cheshire and Merseyside. The FH genetic testing service is vital to making a diagnosis of the condition. Once identified, treatment with lipid-lowering therapy can reduce the risk of CVD.

Case Study - Familial hypercholesterolaemia (FH): Simon's Story

In 2015, after Simon's brother suffered a heart attack while playing football, it was discovered that he had high cholesterol.

Tragically, a week after the heart attack Simon's brother passed away. All immediate family were subsequently offered a number of tests and Simon was identified as having high cholesterol and placed under the care of Leighton Hospital.

In 2022 Simon was referred to the FH service for genetic testing to help him and his family get an answer as to why they were suffering with high cholesterol. Simon was guided through the process and, a couple of months later, received confirmation that he had FH. This diagnosis has enabled additional members of the family to be tested and treated - as well as giving them a greater understanding of what may have caused his brother's death.

Simons brother's son, who was just four at the time of his dad's death, has now been tested and has also been diagnosed with FH. He has already begun treatment to manage his cholesterol and reduce his risk of future heart disease. Simon and his family have expressed their gratitude for this service and the benefit it has provided.

Smoking

Smoking remains the leading cause of preventable illness and death in Cheshire and Merseyside. Smoking causes 20,652 hospital admissions in Cheshire and Merseyside every year and 3,435 early deaths. Smoking is also the leading cause of health inequalities - accounting for half the difference in life expectancy between the richest and poorest in society.

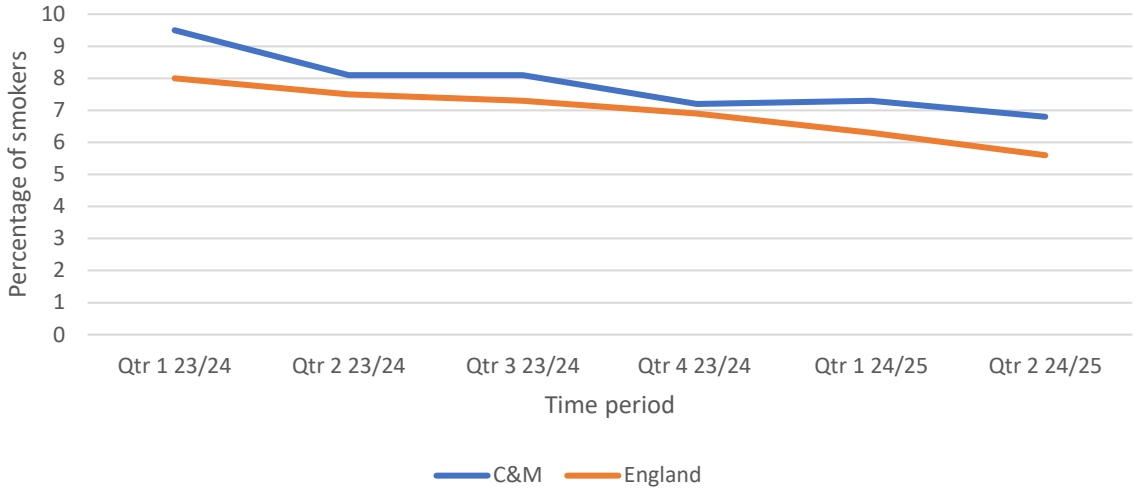
Smoking rates are highest among people who are homeless, entering prison or living in social housing. A total of 9,716 people are currently out of work in Cheshire and Merseyside due to smoking-related illnesses.

Current Performance

Smoking at Time of Delivery

We continue to see improvements in smoking at time of delivery rates across Cheshire and Merseyside with an ongoing downward trend and a narrowing of the gap between local rates and those for England (Figure 21).

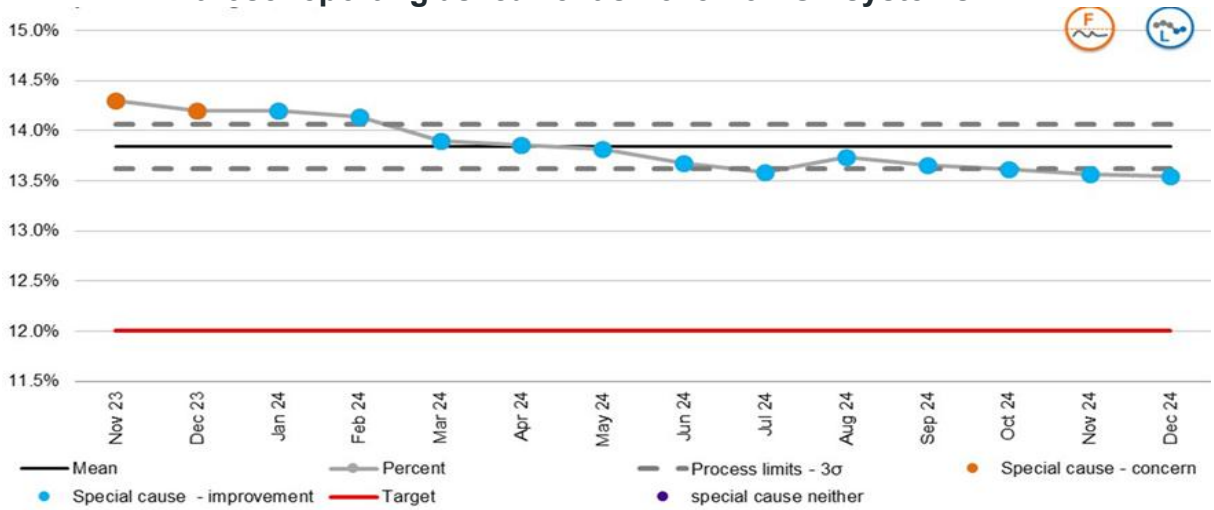
Figure 21 Smoking at time of delivery



Smoking Prevalence – Percentage of those reporting as 'current smoker' on GP systems

Smoking prevalence on GP systems reduced from 13.8% to 13.5% during 2024-2025 (Figure 22). This remains higher than the target of 12%.

Figure 22 Cheshire and Merseyside Smoking Prevalence – percentage of those reporting as 'current smoker' on GP systems



Action undertaken in 2024-2025 to deliver improvements in performance

- **All Together Smokefree** is the Cheshire and Merseyside programme to deliver the ambitious commitment of ending smoking for everyone, making Cheshire and Merseyside completely smokefree by 2030. NHS Cheshire and Merseyside (alongside the nine Local Authorities and their Directors of Public Health) have commitment £5m of Health Inequalities funding into a three-year programme of work to deliver of this ambition through a combination of advocacy, education, partnerships, tackling illicit tobacco and vapes, creating smokefree environments, regulation, intelligence and support.
- **Smoking Ends Here** is a public-facing campaign developed as part of the All Together Smokefree programme. Launched on No Smoking Day (12th March 2025) the campaign saw the St John's Beacon Tower in Liverpool lit up with key health messages and encouraged smokers to

visit the new smokingendshere.com website, which has been co-produced with people from a number of our most deprived communities.

Case Study - Advocacy Tobacco and Vapes Bill

Advocating for additional legislation that further limits the availability of tobacco, tobacco products and vapes for those not using them a quitting aid is crucial to achieving a smokefree generation.

As part of the All Together Smokefree Programme two young people from Kirkby - Lee Shields and Liam Tyrer - attended the All-Party Parliamentary Group on Smoking and Health in the Houses of Parliament to advocate for a smokefree generation for young people.

Both are extremely supportive of the return of the Tobacco and Vapes bill and wrote to their MP, Anneliese Midgley, urging her to support the Bill.

- **Treating Tobacco Dependency inpatient services** have now been established in all inpatient services across all the hospitals in Cheshire and Merseyside. Every patient admitted into hospital now has their smoking status assessed and recorded. All smokers are then referred to the in-house treating tobacco dependency service where they are given Nicotine Replacement Therapy (NRT) or other stop smoking medications alongside a tailored plan to support them to remain smokefree while in hospital. Patients who want to continue their quit attempt when discharged from hospital are referred to community stop smoking services.
- **Treating Tobacco Dependency maternity services** have been fully established since April 2024. All women have carbon monoxide monitoring completed at their booking appointment and those identified as smokers or using tobacco products are referred into a dedicated service for pregnant women where they are offered a combination of Nicotine Replacement Therapy, vapes and a tailored support plan.
- **Saving Babies Lives** - support to quit in pregnancy is also a crucial part of the government's commitment to improving maternity services in England. Smoking remains the leading cause of preventable poor pregnancy outcomes, with smoking in pregnancy increasing the risk of premature births, stillbirths and low birth weight babies. As part of the Saving Babies' Lives Care Bundle we are providing tobacco dependency treatment services in all our maternity services. The additional support offered to pregnant women has resulted in the smoking at time of delivery rate for Cheshire and Merseyside reducing from 8.1% in quarter two of 2023-2024 to 6.8% in quarter Two of 2024-2025.

Case Study – Smoking at time of Delivery

It is crucial that women who are still smoking when they discover they are pregnant are supported to quit as soon as possible.

Recognising the importance of quitting early, the Cheshire and Merseyside Local Maternity and Neonatal Service - in partnership with Mid Cheshire Hospitals NHS Foundation Trust - piloted offering women who use tobacco products smoking cessation support before their booking appointment.

This approach ensures that women are supported as early as possible to quit, which significantly reduces the risk of pregnancy complications such as premature birth and low birth weight babies.

This project was recognised for its innovation by the Royal College of Midwives when shortlisted for the 'Excellence in Midwifery Public Health' award.

The Cheshire and Merseyside NHS Prevention Pledge includes a pledge to '*ensure a smokefree environment, linked to support to stop smoking for patients and staff who need it*'. To support NHS Trusts to achieve this pledge a baseline assessment was undertaken of each NHS Trust's progress. Work will be undertaken in 2025-2026 to standardise smokefree policies across NHS Trusts in Cheshire and Merseyside.

1.2.3.10 Continuing Healthcare

Spending on All Age Continuing Care in Cheshire and Merseyside has increased significantly in recent years and is among the highest of all Integrated Care Boards in England. As such, a key objectives in 2024-2025 was to better understand the reason for this position and ensure services were operating efficiently, effectively and delivering best value for our population.

Transfer of All Age Continuing Care services from outsourced delivery models led to a review of the operating model, leadership, governance and accountability arrangements, performance management, systems and reporting.

The All Age Continuing Care team has worked hard to ensure that there is consistent application of the national framework for NHS continuing health care and NHS funded nursing care. While not all the national key performance indicators were achieved, significant improvement was achieved.

In July 2024, an All Age Continuing Care recovery programme was established to help bring spending in line with the NHS England average. Efficiencies were

identified and significant savings were made, but further work is needed to ensure maximum value for money in 2025-2026.

Working as one team across Cheshire and Merseyside, clinicians and managers worked together to embed a new staffing model and a business intelligence dashboard was established to identify where savings could be made. To support our teams, additional expertise was brought in from external agencies while highlighting and sharing best practice across the organisation. Governance arrangements have also been streamlined, leading to clearer lines of accountability and better decision-making processes.

Case Study – Personal Health Budgets (PHBs)

Simon is 38, has a high-level spinal injury and associated complex needs. He lives alone with no active involvement from his family, but enjoys going to concerts and the cinema with friends and watching Manchester Utd.

When Simon was referred to NHS Cheshire and Merseyside's Personal Health Budget service he was using an agency for his care and support needs - most of which was undertaken by a small team of personal assistants who had worked with him for a long time.

The personal assistants had raised concerns about their employment terms and the agency was not able to cover sickness or holidays. Simon felt that the agency was not behaving in a professional manner.

In response, we supported Simon to hold most of his personal health budget as a direct payment, find a new agency and recruit personal assistants who were adequately trained to meet his needs.

Simon is now supported at home by people he has chosen to employ. He has choice and control over his care, support of an agency that he has confidence in, access to advocacy support and a point of contact if he has any queries.

In 2025-2026 more collaborative work is required with Local Authorities to develop joint policies, while work is ongoing to implement a single digital case management system.

1.2.3.11 Maternity, Neonatal and Women's Health Services

NHS Cheshire and Merseyside Women's Health and Maternity (WHaM) Programme incorporates the leadership of the Local Maternity and Neonatal System (LMNS) and the delivery of the local priorities set out in the national 10-year Women's Health Strategy.

NHS Cheshire and Merseyside's commitment to safety and improving services has been at the forefront of the work of the programme this year.

Local Maternity and Neonatal System

The Local Maternity and Neonatal System has successfully delivered the key actions of year two of the NHS England three-year delivery plan to improve safety in maternity and neonatal services. This includes progress on the national maternity safety ambition to halve the rates of stillbirths, neonatal and maternal mortality; and intrapartum brain injuries while reducing the rate of pre-term births to 6% by March 2025.

Performance against national maternity safety metrics shows that NHS Cheshire and Merseyside:

- is performing better than the England average for stillbirth rates.
- has met the national pre-term birth rate target of 6%, with a mean of 5.9% achieved.
- has reported the following neonatal mortality rates for the period 23rd January to 24th December 2024:
  - Neonatal Intensive Care Unit (NICU) mortality rate of 2.5 per 1,000 live births compared to a North West average of 2.3
  - Neonatal non-NICU mortality rate of 0.4 per 1,000 live births compared to a North West average of 0.5
  - a reduction in intrapartum brain injuries over the last 12 months.

Regular monitoring of safety metrics has been strengthened by the development of a Clinical Metrics Reporting Pack and a Maternity and Neonatal Safety Oversight Group which reviews trends, performance and incidents with shared learning, to identify improvements across the system with all Trusts.

Themes identified in 2024-2025 included leadership and culture, delays in induction of labour and communication. System-wide quality improvement projects have been initiated as a result.

All maternity providers were supported to achieve the 10 safety actions set out in the annual Maternity Incentive Scheme for Trusts (MIS Year 6) - including the Saving Babies Lives Care Bundle - through quarterly support meetings.

A Joint Oversight and Support Framework was implemented for Trusts requiring additional support, with monitoring and mutual aid meetings stood up where any maternity service required assistance from others.

Workforce pressures and impact on services were consistently monitored by the development of an electronic safety tool for maternity which has supported vacancy reduction and support for staff sickness.

Additional system-wide improvement is supported via collaborative networks for Preterm Births, Foetal Medicine and the Cheshire and Merseyside Maternal Medicine Centre - all working in partnership with the North West Neonatal Operational Delivery Network to help improve outcomes for babies and mothers.

Key Achievements in 2024-2025

- implementation of Maternity Treating Tobacco Dependency Services by all Cheshire and Merseyside NHS Trusts led to a reduction in the number of women smoking in pregnancy and at the time of delivery (from 11.3% in March 2023 to 6.3% in December 2024).
- roll-out of 13 Enhanced Midwifery Continuity of Carer teams to provide care in the most vulnerable and complex pregnancies - the highest number nationally for any ICS.
- continued delivery of Personalised Care and Support Plans as standard for all women in Cheshire and Merseyside.
- development of a Cheshire and Merseyside Infant Feeding Strategy to improve breastfeeding rates and support best start for life for all babies.
- good progress with the delivery of the Cheshire and Merseyside Equity and Equality Action Plan, including:
  - **roll-out of the Maternity Health Justice** offer for all women in the perinatal period which won the Lexis Nexis Legal Services Innovation Award.
  - third year of **Baby Week** raising awareness of prevention and health inequity in partnership with Northern Rail, Liverpool Libraries and Museums and other partners.
  - **Holding Time Project** – an artist led programme using photography, social media, and therapeutic writing to address cultural barriers to breastfeeding with prominent displays in local hospitals. Winner of the Royal Society for Public Health 'Health & Wellbeing Award' *National Arts in Hospitals Network* 2024.
  - **ESOL Stepping Stones** - shortlisted for British Council awards and winner of RCM Excellence in Midwifery and Public Health.
  - **Lullaby Project** - responding to perinatal mental health crisis with personalised creative music making, reflecting the need for early engagement to help address ethnic and socio-economic disparities in maternal mortality rates.
  - **Silver Birth Hubs** – providing maternal mental health support for Birth Trauma and psychological distress as a result of pregnancy, bereavement and pregnancy loss.
  - **Improving Health Literacy** with a focus on non-English speaking pregnant women within the most socially deprived and ethnically diverse neighbourhoods - shortlisted for the National BAME Awards.
  - Evidence to the **House of Lords Select Committee** on the impact of preterm birth for families and the improved outcomes as a result of the preventative initiatives Cheshire and Merseyside have implemented.
  - **Peer Support** - with a focus on supporting vulnerable women and families during pregnancy and in the postnatal period.
  - Provision of forums and networks to listen to and act on the experiences of women and families via the local **Maternity and Neonatal Voice Partnerships** (MNVPs) and community engagement team.
  - **Ongoing community engagement** - to obtain insight into the barriers to accessing maternity care, with a focus on Black and Asian women, women living in socially deprived areas across Cheshire and Merseyside, refugee and asylum-seeking women.

Women's Health

The national **Women's Health Strategy**[7] made clear that change was required to improve health and social outcomes for all women, girls and those assigned female at birth. NHS Cheshire and Merseyside's Women's Health and Maternity programme continued to raise awareness of the inequity that 51.6% of the local population face due to gender, while working to improve outcomes and redress the imbalance to life expectancy.

Women's Health Hubs

The development of Women's Health Hubs was a priority for all Integrated Care Boards in England for 2024-2025. Women's health hubs bring together healthcare professionals and services to provide integrated women's health services in the community, centred on women's needs across the life course. They aim to address fragmentation in service delivery to improve women's health access, experiences and outcomes.

The response to this vision has been particularly strong across all nine places in Cheshire and Merseyside via leadership and collaboration, with all places committed to developing women's health hub service models. Initially this focus was on the provision of Long Acting Reversible Contraception (LARC) for all indications to emulate the successful model in the Liverpool Primary Care Hub which resulted in 150% activity uplift in LARC compared to pre-pandemic rates.

Case Study – Women's Health Hubs, Liverpool

Thousands of women in Liverpool can now access more women's health services closer to home.

Women's health hubs have been established by Liverpool's primary care networks (PCNs) with the help of the local NHS and Liverpool City Council.

The hubs, based inside a number of GP surgeries across the city, can be accessed via a referral from a GP and bring together healthcare professionals and existing services to provide integrated women's health services in the community.

Long-acting reversible contraception (LARC) prescribing rates in Liverpool GP practices have increased from 13.1 per 1,000 women prior to the adoption of the new model, to 21.9 per 1,000.

The hubs have also contributed to an increased uptake of cervical screening, by providing women the option of having their contraception and screening needs met in one integrated appointment.

Through the development of a Women's Health Hub Forum and partnerships with local authority commissioners, primary care, sexual health and secondary care, a range of models have emerged to provide access to a wider range of services and support than initially planned.

[7] https://www.gov.uk/government/publications/womens-health-strategy-for-england (last checked 02.06.25)

Key benefits of this neighbourhood model provide direct benefits to women in terms of timely access to services, diagnostics and treatment and referral (to the most appropriate setting) only if required. Feedback from patients and healthcare professionals is extremely positive with an estimated economic benefit of £5 return on investment for every £1 spent on implementing Primary Care Network-sized women's health hubs.

Achievements in 2024-25

- the establishment of seven Women's Health Hub service models across Cheshire and Merseyside - delivering five of the eight services listed within the Department of Health and Social Care's Core Specification. This has highlighted areas of good practice including menopause service provision, cervical screening, pessary fitting and inter-practice referral.
- development of Cheshire and Merseyside Women's Health and Maternity App, to improve communication, access to health information from trusted sources and empower women to make the best decisions for themselves and their families. Including clinically endorsed information for menopause, endometriosis, cervical screening, fertility, pelvic health, and pregnancy. Provides booking and referral options to right care in right place by the right professional. Offering a virtual one stop shop for women and girls, translating into 75 languages it has received 100% positive feedback from women and healthcare professionals since its launch in January 2025.
- supported a collaborative project with the Eve Appeal and the Cheshire and Merseyside Cancer Alliance to deliver Gynaecology Cancer Awareness workshops within community settings for women from black and south Asian communities to raise awareness of the signs and symptoms of gynaecological cancers.
- led menopause information sessions and the roll-out of local menopause pilots to help reduce gynaecology waits.
- delivered Long-acting Reversible Contraception and menopause training to GPs to upskill Primary Care clinicians and improve access and provision.
- continued system collaboration to further develop the capacity of the Living Well Bus to increase Cervical Screening rates and improve access for other screening and health improvement.
- pathways and support for wider non-gynaecological conditions for the prevention of ill health and self-care for long term condition.
- collaborative partnership between Liverpool City Region Combined Authority – Economies for Healthier Lives and Digital Inclusion Network around women's health.

Gynaecology

Access to Hospital-based Gynaecology services, diagnostics and treatment has remained a challenge since before the Covid pandemic and all health care providers are working collaboratively via the Gynaecology Network to improve this.

Key actions to address this include:

- special interest groups for Endometriosis, Menopause, Paediatric and Adolescent Gynaecology and Women's Health Hub Forum.

- Liverpool Women's Hospital Menopause pilot: Reduced waits from **52 weeks to 25 weeks**. Blueprint Standard Operating Procedure developed to support replication across the system.
- insight and audits show **25%** women could be seen in community setting.
- reason For Referral Audit: top Reasons are **Menopause** (Hormone Replacement Therapy) & **Heavy Menstrual Bleeding**
- Referral Optimisation pilot led by Mid Cheshire Hospital Trust reduced referral rates to **46 weeks** to be adopted across the system.
- workforce development with LongActing Reversible Contraception fitting and Menopause training for GPs to increase knowledge and capacity for women's health conditions.
- theatre utilisation optimisation and mutual aid via Gynaecology Operational Managers Network
- Gynaecology Network visits to all Trusts in 2024 to agree targeted action plans and system specific improvements leading to:
  - Length Of Stay less than 2 days for minimal access hysterectomy for benign condition; improved from **68.6%% to 74.6%**
  - Minimal access rate for patients receiving hysterectomy for cancer improved from **39% to 56.5%**
  - % of outpatient attendances performed remotely: **Q2 24/25 19.1% (**highest quartile nationally)
  - % of Patient Initiated Follow Up per appointment; improved from **0.9%** in June 2022 to **4.9%** in September 2024.

Liverpool Women's Hospital Services

The Women's Hospital Services in Liverpool Programme was established with a specific focus to develop a clinically sustainable model of care for hospital-based maternity and gynaecology services delivered in Liverpool.

The programme of work has developed during 2024-2025 to assess the current clinical risks and issues in hospital-based maternity and gynaecology services in Liverpool and develop short, medium and long-term solutions and proposals for mitigating, controlling and resolving the risks and issues.

The key benefits will be improved clinical, quality and experience outcomes for women and their families using these services. The programme has an established governance framework in place and has developed a Case for Change following clinical and stakeholder engagement across the system.

Public Engagement has been ongoing via face-to-face events and online surveys and a panel of lived experienced experts appointed. A public engagement report was presented to the NHS Cheshire and Merseyside Board in March 2025.

Case Study – Best for Baby Too (Liverpool)

A moving film which captured maternity experiences of six women in the asylum system received a rapturous ovation when it was showcased in Liverpool in September 2024.

The premiere of the poignant hour-long film *'When you know.. childbirth in the asylum system'*[8] was attended by dignitaries including Lord Mayor of Liverpool Richard Kemp CBE and Vice Lord Lieutenant of Merseyside Ruth Hussey OBE.

The film was also endorsed by Dame Lesley Regan – England's first ever Women's Health Ambassador.

Event co-organiser Dr Bryony Kendall, a Liverpool GP and safeguarding lead for NHS Cheshire and Merseyside, said the film, which had been two years in the making, will be utilised as a training resource for undergraduate midwives.

"Every maternity journey is different but women in the asylum system often face additional barriers," she said. "Language issues, financial security and access to warm, comfortable housing can all have an impact on people's maternity journeys.

"We are incredibly grateful to the mothers who shared their experiences of the asylum system and maternity care. My message to them is simple. Your voices are being heard, your experiences matter and your bravery in sharing them will lead to better care."

1.2.3.12 Children and Young People (including safeguarding)

Safeguarding

NHS Cheshire and Merseyside delivered its statutory safeguarding duties throughout 2024-2025 by safeguarding children, young people and adults at risk.

The Executive Director of Nursing and Care holds the statutory accountability for safeguarding and is supported by the Deputy Director of Nursing and Care, Associate Director of Safeguarding and Head of Safeguarding. The undertaking of the ICBs statutory safeguarding responsibilities and functions are also delegated to Place Associate Directors of Quality and Safety and their Place-level teams.

NHS Cheshire and Merseyside can demonstrate that there are appropriate safeguarding governance systems in place for discharging statutory safeguarding duties and functions in line with the key safeguarding legislation.

[8] https://nhsrho.org/resources/when-you-knowchildbirth-in-the-asylum-system/ (last checked 02.06.25)

Safeguarding governance is via the System Oversight Board, and quarterly assurance reports to the ICB Quality and Performance Committee which provide the Committee with details on how our statutory functions are being delivered, any learning from safeguarding reviews and system response as well as being sighted on any emerging themes and risks including the required actions to improve and strengthen arrangements.

The System Oversight Board has safeguarding system oversight to give assurance that NHS Cheshire and Merseyside is meeting its statutory duties and against the Safeguarding Children, Young People and Adults at Risk NHS: Safeguarding Accountability and Assurance Framework 2022 (SAAF).

During 2024-2025, assurance of NHS commissioned services continue via quality schedules, safeguarding Key Performance Indicators, NHS England commissioning standards, Section 11 audits, action plans and self-evaluation frameworks.

NHS England requires the ICB to submit a response to the requirements of the SAAF. The ICB has submitted its Safeguarding Self-Assessment to provide assurance of its arrangements and evidence in how the framework is met. The finding demonstrates the same findings as per the previous year; compliance with all measures except for compliance with the safeguarding workforce capacity which remains the area for progression, with an interim business continuity plan in place and plans to move to full mandated compliance.

As an organisation, NHS Cheshire and Merseyside have supported and contributed towards 117 statutory safeguarding reviews. We disseminate learning from national and local reviews across the ICB and wider partnership.

In line with the updated Working Together to Safeguarding Children guidance, we have our Director of Nursing and Care as executive lead for safeguarding and our Place Associate directors as delegated safeguarding partners at Place level.

Other key pieces of work currently being undertaken by the team include:

Children in Care and Care Experienced Children and Young People:

- ensure a seamless approach to requesting and conducting initial health assessments for all children who enter care.
- ensure the voice of the Child shapes our Children in Care strategy
- recruit, train, and mentor care leavers into Band 2 NHS roles, providing them with sustainable employment opportunities and tailored support.

Domestic Abuse and Sexual Safety:

- development of a steering group to oversee implementation of legislation associated to Domestic Abuse and Sexual safety
- recruitment, training and delivery of 100 Domestic abuse and Sexual safety workplace allies across our integrated system with a community of practice for the allies.

The Safeguarding Service will continue to support delivery against safeguarding responsibilities and statutory functions and to develop the key safeguarding priorities so that we remain responsive, creative, flexible to demands and work positively across the system to support developments and ensure safeguarding process and practice is effective and robust.

NHS Cheshire and Merseyside have contributed to the Annual Reports of each of the nine safeguarding partnerships in Cheshire and Merseyside, and which outline key achievements and priorities for each Place. Each annual report and updated Multi-agency Safeguarding Arrangements (MASA) can be found via details available on the websites of each of the nine Local Authorities within Cheshire and Merseyside.

Special Educational Needs and Disabilities (SEND)

NHS Cheshire and Merseyside has a statutory duty to comply with the Children and Families Act (2014) and SEND Code of Practice (2015) to ensure a holistic approach is taken to identify, assess and meet the education, health and social care needs of children and young people aged 0-25 years with SEND.

Overseen by the NHS Cheshire and Merseyside's SEND Collaborative Unit, Designated Clinical Officers deliver statutory functions within Place-based SEND partnerships.

Four key SEND areas for NHS Cheshire and Merseyside in 2024-2025 included:

- ***Cheshire and Merseyside SEND Data Dashboard*** - significant work between Business Intelligence and SEND Collaborative Unit colleagues led to the development of an integrated core SEND dashboard for Cheshire and Merseyside.

- ***Partnerships for the Inclusion of Neurodiversity in Schools (PINS)*** - funded by the Department for Education, the national PINS project was delivered to 37 primary schools across seven of Cheshire and Merseyside's Places in conjunction with local Parent Carer Forums. 37.5 hrs of training and on-site specialist support enabled schools to increasingly meet the needs of neurodiverse children and young people - targeting reducing exclusions and strengthening pupil wellbeing.

- ***Learning Disability Pathway*** - Transforming Care Partnership funding supported the development of an approved Cheshire and Mersey-wide learning disability diagnostic pathway, with an established central steering group overseeing implementation by nine local steering groups.

- ***SEND Inspection*** - inspection readiness and response remains a priority. To date, three inspections in Cheshire and Merseyside under the new framework for Area (SEND) inspections 2023 have resulted in varying outcomes:
  - Warrington Place - inconsistent experiences and outcomes
  - Halton Place - widespread and/or systematic failings (SEND improvement notice issued)
  - Wirral Place - outcome currently embargoed (SEND Improvement Notice previously issued).

Cheshire and Merseyside Children and Young People's Committee

Throughout 2024-2025, the support that the Cheshire and Merseyside system offers to meet the needs of children and young people continued to evolve. A strong strategic focus on children as a population cohort is overseen by a Cheshire and Merseyside Children and Young Peoples Committee which has a single line of sight for all delivery, alongside key priority areas including:

- Mental Health / Appropriate Places of Care
- Oral Health
- Neuro-Diversity
- Children on the Edge of Care.

Case Study – Delivering better outcomes for children and young people

Commissioned by NHS Cheshire and Merseyside, a thought-leadership report entitled 'Harnessing system working to deliver better outcomes for children and young people' was published in November 2024.

Endorsed by NHS Cheshire and Merseyside's Chair and the Children and Young People's Committee, the report reveals that more than 40% of children across Cheshire and Merseyside are currently living in poverty.

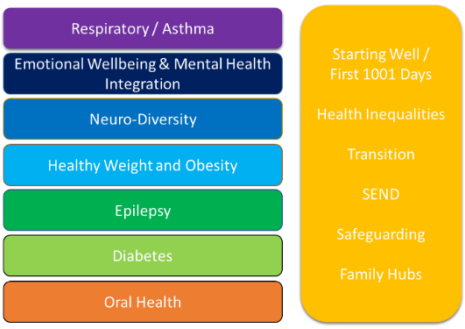
Too many are classed as overweight or obese, many do not achieve the expected level of development at the end of Reception and poor mental health is on the rise.

It recommends that the Cheshire and Merseyside system works to embed:

- Early Intervention – An opportunity to mitigate family risk factors, such as substance abuse and mental health.
- Incorporating Lived Experience – Giving a voice to children and young people about services that affect their lives.
- Community-based Interventions – Community assets serve as an alternative and economically viable approach to public service delivery.
- Evidence-Led Approaches – Being able to demonstrate the tangible impact of interventions.
- Networked Work – A co-ordinated approach to tackle the complex challenges faced by vulnerable children and young people - establishing joint solutions to prevent young people from slipping through the cracks.

Beyond: Children and Young People's Transformation Programme

The Beyond programme, established in 2021, supports a population health approach to the needs of children and young people. Priority areas reflect Joint Strategic Needs Assessments, the NHS Long Term Plan and CORE 20+5, with a focus on integrated early intervention and prevention to address wider determinants of health outcomes.



Data science remains embedded and aligns with NHS Cheshire and Merseyside programmes including Data into Action and Population Health Intelligence. This enables identification of health inequalities to support risk stratification and focus interventions.

Respiratory: NHS Cheshire and Merseyside continues to deliver the asthma bundle of care: 171 Asthma friendly schools are in development with seven already accredited. Smoking / vaping prevention was delivered to 5,458 children and young people in 50 schools. A discharge bundle has resulted in more inhaler technique reviews and Personalised Asthma Action Plans. The Digital Health Passport has 299 downloads and 1,798 interactions.

Emotional Wellbeing and Mental Health: A model for "Appropriate Places of Care" for children and young people with complex multi-agency needs has been co-produced across health and social care.

Neurodiversity: A Needs-Led Model for children and young people with Neurodiversity is under development. Work will continue into 2025-2026, including implementation of minimum support standards, a consistent and streamlined assessment pathway and standardised ongoing support offer.

Healthy Weight and Obesity: The HENRY Project supported more than 490 families. The Halton digital app engaged 250 children and young people including access to leisure, equipment vouchers, training as health champions and health improvement/nutrition training for professionals. Why Weight to Talk trained 353 staff in conversations about healthy choices. The People's Health Project in schools directly supported 200 children and young people and 43 parents in healthy weight sessions.

Epilepsy: NHS Cheshire and Merseyside continues to deliver the epilepsy bundle of care. Epilepsy Nurse Specialists have increased access of young people to specialist care. Two Youth Workers have been employed within hospitals to support children and young people with epilepsy. An Integrated Epilepsy Specialist Nurse has facilitated access to specialist care and supported the development of transition pathway.

Diabetes: A Diabetes technology pilot supported 309 children and young people, while a Transition and Young Adult Pilot supported staff recruitment, regular clinics and joint multi-disciplinary team meetings.

Oral Health: All Together Smiling - three-year supervised toothbrushing programme has mobilised across all nine Places in partnership with Local Authorities and Public Health. Of the 300,000 toothpaste and brush oral health packs distributed, 4,623 of the families to benefit are families with a child or young person with SEND. This distribution was directly supported through a parent champion model.

Participation: The Children and Young People's Committee uses Lundy principles with young people regularly attending meetings to share their perspectives. 73 children and young people and 300 professionals shared their views on the NHS 10-year plan consultation. Their insights were included in Cheshire and Merseyside's response.

Case Study – All Together Smiling

Hundreds of thousands of children across Cheshire and Merseyside received free dental care packs in 2024-25 to help them to prevent tooth decay and develop healthy habits for life.

NHS Cheshire and Merseyside's All Together Smiling supervised toothbrushing programme is aimed at reducing the need for dental treatment for children under ten in the region's most deprived areas.

Delivered through Beyond, hundreds of thousands of toothbrushes, tubes of toothpaste and 'how-to' guides were distributed across Cheshire and Merseyside's nine places.

Tooth decay remains the leading cause of hospital admission for children aged five to nine, with those living in the most deprived communities 3.5 times more likely to have a decaying tooth extracted than children in more affluent areas.

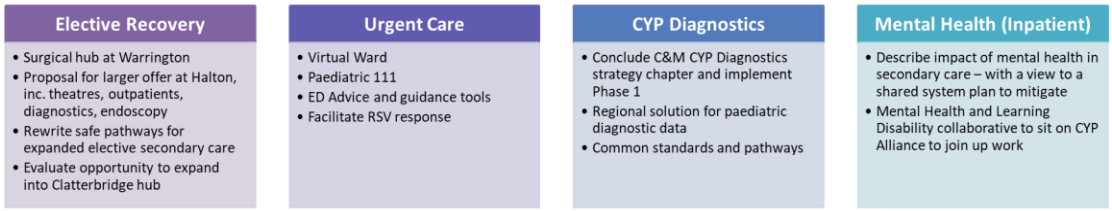
According to 2022 data from the National Dental Epidemiology Programme, 30.7% of children aged five across Cheshire and Merseyside had tooth decay compared to 23.7% nationally.

Children and Young People's Alliance

Formed in November 2023, the Children and Young People's Alliance brings together senior leaders from member NHS Trusts to improve access and drive service improvements for children and young people by collaboratively delivering against agreed core priorities and projects.

The vision of the alliance is to ensure **All Cheshire and Merseyside children and young people with health needs will receive the right care in the right place.**

Workstreams



1.2.3.13 Quality and patient safety (Improve quality)

Quality and patient safety are key priorities for NHS Cheshire and Merseyside, with key quality metrics consistently monitored to observe progress. The following summaries describe the quality metrics used and the work undertaken to drive improvement through 2024-2025.

Health Care Associated Infections
Clostridium Difficile (CDI) rates continued to be a challenge during 2024-25 and exceeded the nationally set tolerance. This was a focus in quality improvement with a task and finish group led by Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST). This group has developed a Clostridium Difficile reduction toolkit with clear actions for NHS Trusts to deliver and to be monitored through quality contract discussions.

The impact of the toolkit has been observed in Quarter 4 with a 20% reduction (254) from Quarter 3 position (317) based on all case types. However, to deliver under tolerance a further 10% reduction will be sought in 2025 -2026.

E. Coli rates also continued to be a challenge and have exceeded the nationally set tolerances. As many E. Coli bloodstream infections have a source of Urinary Tract Infection (UTI), a targeted hydration pilot was completed across Cheshire and Merseyside which resulted in a reduction in UTI and, specifically, admissions due to UTI.

Whilst like CDI the ICB annual position breached tolerances, there is evidence of reduction into Quarter 4 with a 13% reduction (500) from the Quarter 3 position (572) based on all case types. If replicated the rate of cases in Quarter 4 would remain below national threshold.

With high rates of E. Coli remaining in certain providers across the system, targeted deep dives to seek wider understanding of E. Coli risk factors will support additional preventative action in 2025-2026.

Summary Hospital Level Mortality Rate
This indicator is the ratio between the number of patients who die following hospitalisation in Cheshire and Merseyside and the number that would be expected to die based on the national average, given the characteristics of the patients.

The rate as of November 2024 for Cheshire and Merseyside is 0.984 which is a further improvement from 1.034 in November 2023 - although both are within expected tolerances.

There continues to be one outlier at East Cheshire NHS Trust where continued focus has been supported through Board-to-Board meetings, ensuring appropriate support is in place for improvement.

Never Events
In the 12 months to March 2025 there were 22 Never Events reported across Cheshire and Merseyside, compared to 26 in the previous 12 months.

The majority of Never Events (21) relate to surgical or other invasive procedures. To explore the system-wide learning from Never Events, other surgical safety incidents and invasive procedure quality improvements in more detail, NHS Cheshire and Merseyside has established an Invasive Procedure Clinical Network. The network consists of surgical and invasive procedure safety leads from a range of providers and provides peer review to seek system-wide improvement in this area of practice.

Patient Safety Incident Response Framework (PSIRF)
NHS Cheshire and Merseyside has continued to support the significant cultural shift in responding to patient safety events envisaged through the Patient Safety Incident Response Framework (PSIRF) and the wider Patient Safety Strategy. The Cheshire and Merseyside system now has all 16 NHS Providers and many independent providers responding under PSIRF policies and plans. This has been a significant shift in prioritisation of understanding system factors within local safety critical issues and through appropriate use of resources ensuring that learning and understanding translates into meaningful quality improvement.

Whilst NHS Cheshire and Merseyside continues to support the embedding of processes in these organisations, there has also been a drive to embed principles in other health and care sectors. During the year a focus on Hospice services has seen this sector embrace PSIRF and a pilot with general medical practice has been insightful with regards to the adaptions required to effectively implement within Primary Care. Whilst not complete in year, a further programme to pilot PSIRF across a selection of care homes has been developed and will be completed within 2025-2026.

Alongside supporting the implementation of PSIRF, NHS Cheshire and Merseyside has critically reviewed the role of system oversight for PSIRF. This has led to development of several forums and networks supporting system collaboration in responses and improvement. These fora have also allowed peer discussion and solutions to challenges in the significant cultural shift required.

The analysis of PSIRF priorities and provider incident profiling has been a key factor in consideration of system safety priorities, however additional insight has been sought with key parts of the health and care system, including Primary Care and Social Care, yet to fully embed PSIRF. An initial focus has been drawn to prevention of harms from falls following reference from several NHS providers plans and noted as an area for improvement within system outcome data.

Progress has been observed through an internal audit process providing substantial assurance but also supporting targeted actions for further progress.

System Quality Group
System collaboration around clinical and quality risk and aligned quality improvement remains a priority in Cheshire and Merseyside. The System Quality Group provides a forum for focus on collaborative approaches to quality from all health and care partners. During the year the system quality group has met six times focusing on a range of topics including urgent and emergency care, women's health, mental health and children's services. At each meeting the group have shared quality progress and current challenges to quality, seeking partners to collaborate on improvement programmes.

Urgent and Emergency Care
Urgent and Emergency Care remains an operational challenge within the Cheshire and Merseyside system and nationally. With significant ongoing work to drive improvement in performance within this area, an additional focus has been around the safety of patients affected.

NHS Cheshire and Merseyside has developed a 'Red lines tool kit' in partnership with the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative. This is designed to ensure that safety and quality of care is a defining factor in all decision-making during periods of escalating pressure and has now been implemented within all Urgent and Emergency Care departments across the system.

Case Study – Royal College of Nursing Award

An NHS Cheshire and Merseyside nurse received a Royal College of Nursing (RCN) award to mark her outstanding contribution to equality, diversity and inclusion at the College's annual regional Black History Month conference.

Josette Niyokindi, Associate Director of Quality, Safety and Improvement, received an RCN Outstanding Achievement Award at a ceremony in October 2024 at the Quaker House in Liverpool.

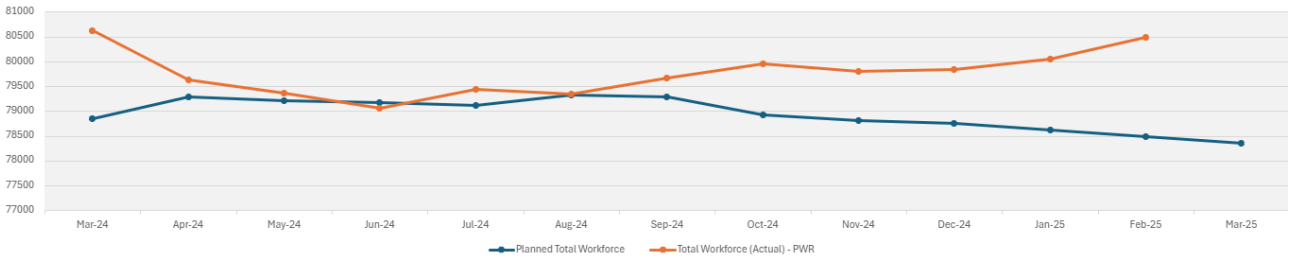
The awards form part of RCN North West's annual event to recognise and celebrate the outstanding contribution of nursing staff who are either from or working with those from ethnic minority backgrounds.

Via these roles, Josette is actively involved in sharing lived experiences of staff from ethnic minority backgrounds to drive organisational change and improving equality considerations during the recruitment process.

1.2.3.14 Integrated Care System Workforce

Workforce and its triangulation with finance, performance and productivity continued to be key focus across the system. 2024-2025 Operational Plans for Cheshire and Merseyside providers were resubmitted in October 2025. Figure 23 shows performance against plan.

Figure 23 Cheshire and Merseyside System Total Workforce – Plan vs Actual (WTE)



The 2024-2025 planning guidance set out an expectation for all providers, with a focus on the acute sector, to improve towards pre-pandemic levels (recognising potential adjustments for case mix change, structural factors and uncaptured activity). 'Implied Productivity Growth' of acute and specialist trusts is calculated by NHS England by comparing output growth (activity) to input growth (based on expenditure costs – including workforce pay) against a baseline period.

The measure examines the current year's Year to Date activity and costs with the same period in 2019-20 and, more recently, with 2023-2024. A negative value implies decreased productivity whilst positive implies productivity growth. Table 8 outlines the position at Month Six 2024-2025.

Table 8

*Productivity Measure	C&M %	North West %	National Average %
Implied Productivity Growth M5 23/24 vs 19/20	-18.8%	-20.2%	-14.3%
Implied Productivity Growth M5 24/25 vs 23/24	0.2%	0.4%	1.6%
Implied Productivity Growth M6 23/24 vs 19/20	-18.9%	-20.2%	-14.3%
Implied Productivity Growth M6 24/25 vs 23/24	0.0%	0.5%	1.8%

*acute providers only

General Practice and Wider Primary Care

It is recognised that for primary medical, many operational issues are managed within each of Cheshire and Merseyside's nine Places to address local challenges in relation to general practice workforce.

The availability of data across NHS Cheshire and Merseyside for all four contractor groups is uneven, and there is currently a resources gap to support this consistently across the primary care and people teams at system level, including management of the system primary care workforce steering group.

The challenges and ambitions for community pharmacy and primary medical in relation to workforce are also detailed in the Primary Care Strategic Framework.[9] Actions relating to the national workforce strategy/plan are managed through the ICBs System Primary Care Committee. The Cheshire and Merseyside Training Hub, commissioned by NHS England, is a key support to delivering some of these ambitions.

The current issues and challenges in Cheshire and Merseyside General Practice were identified as being:

- fewer GPs in areas of deprivation – with ongoing recruitment and retention challenges
- workload is increasing / changing with an increased shift to digital / telephony-based triage & signposting.
- more GPs are leaving or reducing work than ever before
- capacity – both in physical estate and supervision capacity to accommodate new workforce and learners
- General Practice (Registered) Nursing is seeing a slight downward trend and not growing in line with other Direct Patient Contact / ARRS funded roles.

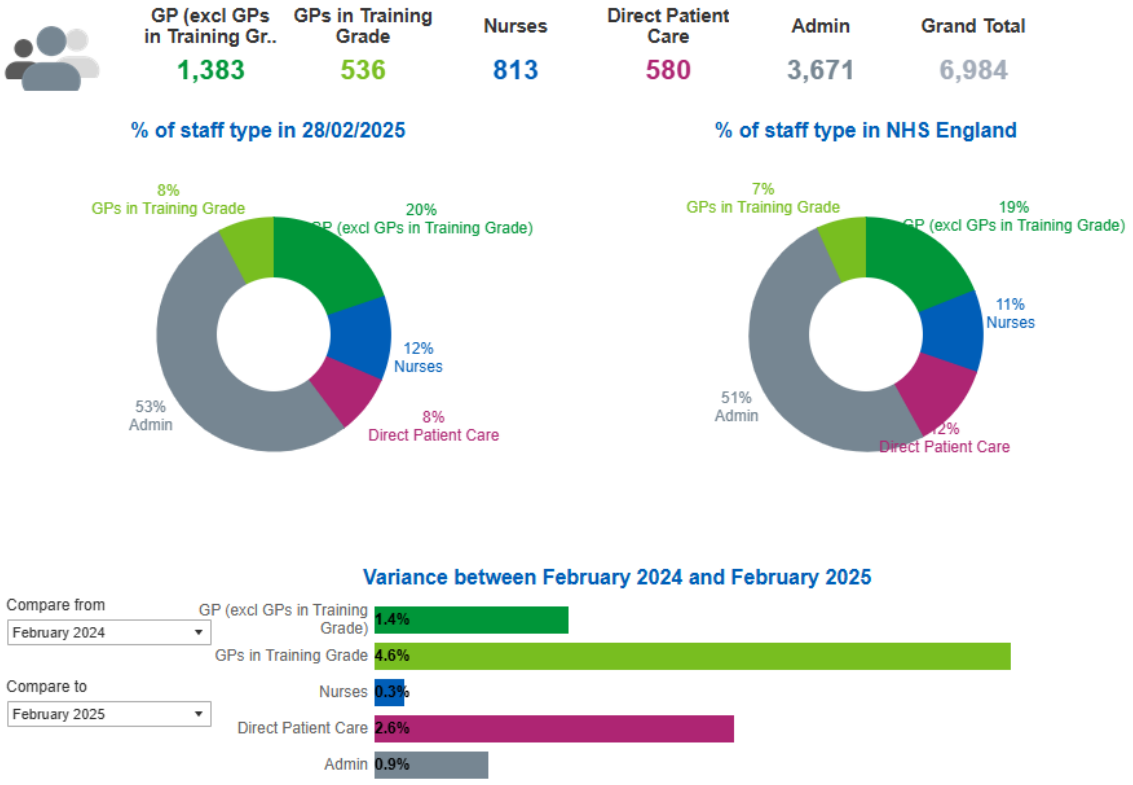
Figure 24 does provide a picture (as of February 2025) of the current Primary Care workforce across Cheshire and Merseyside.

In the context of the data shared around the Long-Term Workforce Plan and the training pipeline, was noted at People Board that number of students who are doing their nurse training is reduced against previous trends, which means there is a risk there will be lower training output to expand / replace and fill the General Practice Nursing posts. Our higher educational partners are working hard to try and increase the numbers of people into nurse training, with innovative recruitment campaigns and support packages for students, and an increase focus on entry level apprenticeship routes – to allow trainees to work, learn and earn.

At the Cheshire and Merseyside People Board in July 2024, it was noted that General Practice were entering into an unprecedented period of Industrial Action, which was expected to have an on the service offer that's made to local people. Having gone through periods of industrial action last year in secondary care, its known and recognised that this impacts people's perception of the NHS and whether it's a place people would want to have a career.

[9] https://www.cheshireandmerseyside.nhs.uk/media/pq0jaumn/cm-integrated-care-board-primary-care-strategic-framework.pdf

Figure 24 General Practice primary Care Workforce – Cheshire and Merseyside (February 2025)



1.2.4 Statutory Duties

The Health and Care Act 2022 conferred a number of statutory duties onto the ICB, which the ICB is committed to fulfilling. The Annual Report demonstrates how NHS Cheshire and Merseyside has discharged its general duties per sections 14Z34 to 14Z45 and 14Z49 of the National Health Service Act 2006 (as amended) (Table 9).

Table 9

Section	Duty	Annual Report Reference
14Z34	Improvement in quality of services	Section 1.2.3.13
14Z35	Reducing inequalities	Section 1.2.3.8, 1.2.3.11, 1.2.3.13, 1.2.7
14Z36	Promote involvement of each patient	Sections 1.2.5, 1.2.3.4, 1.2.3.9, 1.2.3.10, 1.2.3.11
14Z37	Patient choice	Sections 1.2.6, 1.2.3.9, 1.2.3.10, 1.2.3.11
14Z38	Obtain appropriate advice	Corporate Governance Report - sections 2.2.1.4 and 2.2.3.3 to 2.2.3.14
14Z39	Promote innovation	Sections 1.2.3.4, 1.2.3.7, 1.2.9
14Z40	In respect of research	Section 1.2.9
14Z41	Promote education and training	Sections 1.2.3.13 & 1.2.3.14
14Z42	Promote integration	Section 1.2.3.8

Section	Duty	Annual Report Reference
14Z43	Have regard to wider effect of decisions	Corporate Governance Report - sections 2.2.1.4 and 2.2.3.3 to 2.2.3.14
14Z44	Climate change	Section 1.2.5
14Z45	Public involvement and consultation by Integrated Care Boards	Section 1.2.6
14Z49	Keep experience of members under review	Corporate Governance Report - sections 2.2.1.4 and 2.2.3.3 to 2.2.3.14
14Z58 2(d) & 3	Health and Wellbeing Strategy	Sections 1.2.2, 1.2.3.8

1.2.5 Environmental Matters

NHS Cheshire and Merseyside remains steadfast in its commitment to sustainability, aligning with the *NHS Long Term Plan* and *Delivering a Greener NHS*. Climate change is the greatest threat to human health, and our efforts focus on reducing the emissions associated with delivery of our services, improving health outcomes, tackling inequity and ensuring the long-term resilience of services via effective adaptation and planning.

NHS Cheshire and Merseyside's Green Plan 2025 – 2028 was approved by the Board of NHS Cheshire and Merseyside at its meeting March 2025 and replaced the previous Plan covering the period 2022-25. It is our locally tailored roadmap to delivering a sustainable, net zero health service by 2040. Developed in collaboration with system partners, it sets out ambitious targets and actionable initiatives to reduce our environmental impact and build resilience to climate change.

The Plan is closely aligned with the ICBs Annual Delivery Plan, as both frameworks aim to improve health outcomes, reduce inequalities, and ensure the sustainability of healthcare services; namely:

- **Integration of Sustainability Goals:** The Green Plan emphasises reducing carbon emissions, improving resource efficiency, and preparing for climate change, which are integrated into the Annual Delivery Plan to ensure sustainable healthcare delivery. The Annual Delivery Plan incorporates specific actions from the Green Plan to achieve both environmental and operational efficiency.
- **Health Inequalities and Social Value:** Both plans address health inequalities by focusing on the wider determinants of health, such as air quality and access to green spaces. The Green Plan's initiatives are reflected in the Annual Delivery Plan as measures to improve community health and wellbeing. The Green Plan also embeds social value into its strategies, which is mirrored in the Annual Delivery Plan through partnerships with local authorities and community organisations to deliver greener and more equitable healthcare services
- **Operational Efficiency and Cost Savings:** The Green Plan's focus on reducing waste and improving resource efficiency directly supports the Annual Delivery Plan's objectives to optimise operational costs. By aligning sustainability efforts with financial goals, the Green Plan ensures that the Annual Delivery Plan

achieves both environmental and economic benefits.

- **Collaboration and Partnership:** The Green Plan highlights the importance of collaboration with partners, including local authorities, suppliers, and community groups, to achieve sustainability targets. This collaborative approach is also a cornerstone of the Annual Delivery Plan, ensuring that sustainability initiatives are scaled and integrated across the region.
- **Climate Adaptation and Resilience:** The Green Plan's focus on preparing for climate change, such as improving infrastructure resilience and reducing air pollution, is reflected in the Annual Delivery Plan's emphasis on adapting to extreme weather events and ensuring the continuity of healthcare services

Cheshire and Merseyside has been a social value accelerator site since 2018, co-developing a Social Value Charter and establishing a Social Value Award. A range of organisations from the public, private and voluntary sectors have committed to these initiatives, focusing on a collaborative approach to enhancing social value in the region.

This initiative is part of the public sector's responsibility, as 'Anchor Organisations,' to leverage their purchasing power for community improvement. Since its launch, more than 30 organisations have signed the Cheshire and Merseyside Anchor Charter, with a dashboard and regular Anchor Assembly meetings in place to track ongoing progress.

Progress and Highlights

As a system leader, NHS Cheshire and Merseyside is committed to reducing carbon emissions and fostering environmentally sustainable practices, ensuring that all providers are supported to play their part in this critical agenda.

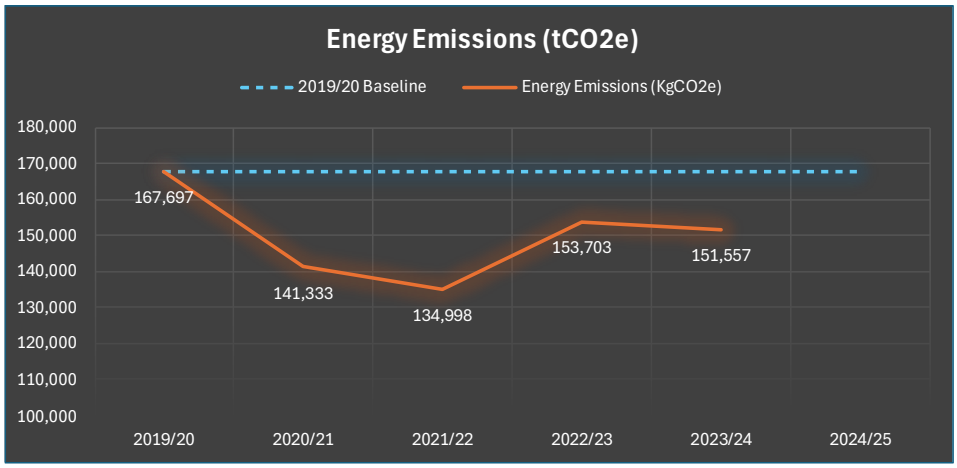
Through collaborative partnerships, shared innovation, and targeted guidance, NHS Cheshire and Merseyside is empowering organisations to implement sustainable solutions, from reducing energy consumption to enhancing green infrastructure. By uniting efforts across the system, NHS Cheshire and Merseyside is not only advancing towards a net zero future but ensuring that sustainability remains integral to delivering high-quality, resilient care.

Highlights from 2024-25 include:

- 92% of our Anchor organisations' workforce reside in Cheshire and Merseyside – with 99% paid the Real Living Wage.
- 100% of Cheshire and Merseyside Anchors deliver initiatives to address health inequity.
- funding secured for 'green' primary care pilot projects which will be developed into case studies for wider roll-out to general practice across Cheshire and Merseyside. Areas of focus included active travel, biodiversity, staff and patient engagement, diabetes lifestyle modification, de-prescribing, medicines optimisation and waste reduction.
- Energy emissions from use of electricity, gas and oil are featured in Figure 25. The reduction in emissions seen in 2020-2022 reflects the impact of COVID-19 on activity, with the rise in subsequent years attributable to healthcare services resuming normal operations and addressing backlogs in treatments and

procedures that were delayed during the pandemic.

Figure 25 Energy emissions – equivalent tonnes CO^2



- the majority of NHS acute Trusts in Cheshire and Merseyside have either decommissioned or begun the process of decommissioning nitrous oxide (NO_2) gas manifolds to eliminate issues with leaking pipework, as recommended by NHS England. NO_2 is a potent greenhouse gas with a global warming potential almost 310 times that of carbon dioxide (CO_2).
- the use of desflurane (a volatile anaesthetic gas with a global warming potential 2,540 times that of CO_2), reduced from 3.10% of volatile anaesthetic gases in February 2022 to 0.9% in March 2023 to 0% in April 2024.

Taskforce on climate-related Financial Disclosures

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under Taskforce on Climate-related Financial Disclosure requirements as these are computed nationally by NHS England. Recommended disclosures will be implemented in sustainability reporting requirements on a phased basis up to the 2025-26 financial year.

For 2024-25, the phased approach incorporates the disclosure requirements of: Governance, Risk Management and Metrics and Targets.

Governance

All decisions and actions with regard to Cheshire and Merseyside's Green Plan are transparent and underpinned by the concept of the triple bottom line - environmental, economic and social pillars of sustainability.

Our Sustainability Board has oversight of delivery, reporting regularly into both the Cheshire and Merseyside Health and Care Partnership and NHS Cheshire and Merseyside Boards. Progress is also reported on a quarterly basis to the North West region's Net Zero Board, which in turn reports to the national Greener NHS team.

NHS Cheshire and Merseyside's Assistant Chief Executive is the executive lead for the sustainability portfolio, with strategic leadership and co-ordination provided by a small sustainability function.

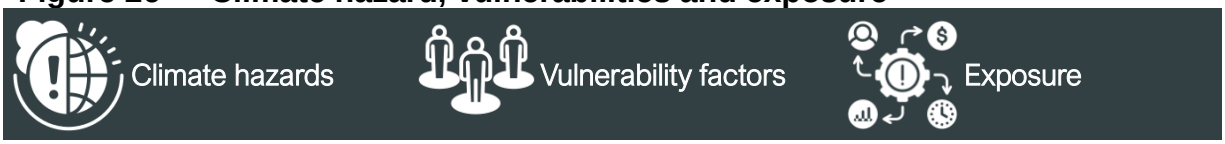
Several thematic sub-groups convene speciality leads from the wider system, with reports regularly shared with other groups including Provider Collaboratives, the Strategic Estates Board, Population Health Board and Health and Care Partnership Board.

Risk Management

NHS Cheshire and Merseyside is committed to a strategic and proactive approach to risk management, particularly in addressing the interconnected challenges posed by climate hazards and their effects.

Climate related events such as flooding, heatwaves and extreme weather have the potential to disrupt healthcare delivery through direct impacts on supply chain, infrastructure and service demand, whilst also exacerbating underlying vulnerabilities within communities. These risks are not isolated - they often intersect - creating cascading effects that amplify pressure on healthcare systems.

Figure 26 Climate hazard, vulnerabilities and exposure



Climate hazards	Vulnerability factors	Exposure
• Extreme weather events	• Demographic	• People / communities
• Heat	• Geographical	• Health workforce
• Sea level rise / flooding	• Biological factors and health status	• Infrastructure
• Air pollution	• Sociopolitical	• Energy systems
• Vector distribution	• Socioeconomic	• Water systems
• Water scarcity	• Health system capacity	• Food systems
• Reduced food production	• Gender and equity	• Health systems

Climate change projections for the UK point to increased temperatures, more frequent extreme weather events and rising sea levels. While it is important to reduce our carbon emissions, it is of equal importance that NHS Cheshire and Merseyside adapts to ensure the resilience of the healthcare system and of communities. A significant amount of climate adaptation work is already underway, with comprehensive adaptation planning prioritised in the Green Plan.

Metrics and Targets

As part of our commitment to the NHS Net Zero strategy, NHS Cheshire and Merseyside is continuing to develop metrics and targets to monitor and reduce climate impact. Key metrics include:

1. **Energy Consumption:** Tracking annual energy use across NHS facilities, including electricity, gas and other fuels.
2. **Greenhouse Gas Emissions:** Monitoring Scope 1 (direct emissions), Scope 2 (indirect emissions), and Scope 3 (indirect emissions from supply chain, travel and waste) emissions.

3. **Renewable Energy Usage:** Measuring the percentage of energy sourced from renewable or low-carbon sources.
4. **Waste Management:** Quantifying waste generated and the proportion diverted from landfill through recycling or sustainable disposal methods.
5. **Sustainable Travel:** Tracking the percentage of staff commuting via low-carbon transport options and active travel, and the reduction in business travel emissions.

Looking Ahead
In 2025-2026 NHS Cheshire and Merseyside will build on the foundations of the refreshed Green Plan, driving innovation and collaboration to achieve our sustainability targets. Key priorities include:

- enhancing the resilience of our infrastructure to climate-related risks, including flooding, heat and high temperatures and extreme weather.
- strengthening our partnerships with local communities and organisations to promote health equity and environmental sustainability.
- expanding renewable energy projects to further reduce carbon emissions.
- reporting on greenhouse gas emissions.
- growing the number of local organisations signing up to our Anchor and Social Value Charters.

1.2.6 Engaging people and communities

In this section, we report on how NHS Cheshire and Merseyside delivered its statutory duties for involving people during 2024-2025.

The main duties on integrated care boards to make arrangements to involve the public are set out in the National Health Services Act 2006, as amended by the Health and Care Act 2022: section 14Z45. NHS England's *Working in partnership with people and communities: statutory guidance* (published July 2022)[1] provides further information about meeting these duties.

However, NHS Cheshire and Merseyside's approach to engaging with our population aims to go beyond what we are required to do by law. It is about creating meaningful opportunities to hear from the people who use and depend on health services, so that their views and insights can improve the care our local NHS provides.

Governance
The Board of NHS Cheshire and Merseyside has responsibility for approving plans for public consultation and our overall communication and engagement plan. In 2024-2025 the Board considered both the organisation's new two-year Involvement Plan and a proposal for public consultation on gluten free prescribing. However, it is important that the governance for involvement activity which falls outside of these tasks is also clear. During 2025-2026 we intend to embed comprehensive governance arrangements for involvement activity, with the intention of establishing:

- assurance and sign-off routes for individual involvement activity plans – including the process for agreeing the required level of involvement.

- clear routes for reporting back on involvement activity, including public consultation, and agreeing any next steps or actions arising as a result of feedback received.
- regular reporting arrangements.

In advance of this, we aim to establish a group which brings together partners to consider and provide feedback about NHS Cheshire and Merseyside involvement plans. Although this already happens on an individual programme basis – for example, both the ICBs Women's Hospital Services in Liverpool and Shaping Care Together programmes have dedicated groups of this kind – the intention would be for the new group to take a system-wide perspective. Discussions around this are underway.

Approach to involvement

During 2024-2025, we published NHS Cheshire and Merseyside's first two-year involvement plan.[10] This was approved by our Board in July 2024, having first been considered by the ICB Quality and Performance Committee, and provides a practical overview of how we will work with people and communities, building on the draft public engagement framework produced in summer 2022 as a newly established organisation.

The plan explains our overall approach to involvement, rather than how we will engage on specific themes, in particular areas or with different groups of people, as it is important that we consider this on a case-by-case basis. It outlines the following ten objectives, which set the direction for how NHS Cheshire and Merseyside will focus its involvement resources during the lifespan of the plan:

1. Ensure that involvement is embedded in our governance and decision-making as an organisation.
2. Ensure that a focus on hearing underrepresented voices underpins our involvement plans
3. Provide a range of different routes for people and communities to be involved in the work of NHS Cheshire and Merseyside.
4. Identify barriers to participation, and design communication and engagement mechanisms which recognise different needs, preferences, and styles.
5. Ensure that tailored plans are developed for involving people in specific programmes and pieces of work, including service change.
6. Ensure that our staff understand our involvement duties and recognise the benefits that come from working with people and communities. Support and empower staff to be proactive in identifying opportunities to embed involvement, including co-production, through their own roles.
7. Actively find opportunities to share involvement skills and best practice amongst our provider organisations.
8. Demonstrate how feedback is used to develop services and influence plans
9. Work with partners to develop and deliver involvement activity, so that we make the most of skills and expertise across the system, while utilising different routes for reaching our audiences.

[10] https://www.cheshireandmerseyside.nhs.uk/media/axxdpdee/final-nhs-cheshire-and-merseyside-involvement-plan-2024-to-2026-25-april-24.pdf (last checked 02.06.25)

10. Look for ways to share the insights we gather with system partners, to maximise the impact of the feedback our local population gives us.

How NHS Cheshire and Merseyside has involved people during the past 12 months

In 2024-25 we continued to develop our engagement infrastructure, while delivering our public involvement duties through a range of different projects and programmes. Over the following pages we provide an overview of some key pieces of work.

Improving Hospital Gynaecology and Maternity Services in Liverpool

The Women's Hospital Services in Liverpool programme was established to look at the issues facing hospital maternity and gynaecology services in the city. Between 15 October and 26 November 2024, NHS Cheshire and Merseyside held a six-week public engagement, inviting people to reflect on a newly published case for change.

Planning involved the Women's Hospital Services in Liverpool (WHSIL) Communications and Engagement Group, which reports to the WHSIL Programme Board, and includes representation from the NHS trusts involved in the programme and local Healthwatch. A Lived Experience Panel for the programme was set up during summer 2024, consisting of local people with experience of gynaecology and maternity services. The panel provided feedback on engagement materials and the questionnaire, providing an important perspective on how this information would be received by the public.

Comprehensive communications were issued to launch the engagement on 15 October 2024. A dedicated programme website went live on the first day of engagement, and a toolkit was cascaded to partner organisations, encouraging them to promote the opportunity to take part on their own channels.

More than 900 people completed the engagement questionnaire, with a majority (88%) either fully or partly agreeing that the NHS had clearly explained why hospital gynaecology and maternity services need to change. At the same time, there was broad support about the need to make changes to these services, with 82% of respondents in agreement.

People were also asked to identify what was most important to them when considering the future of hospital gynaecology and maternity services in Liverpool, with responses highlighting five main themes: Good patient experience; accessibility and equity of care; waiting times and reducing appointment delays; patient safety; and staff compassion and competence.

Six public engagement events took place during the six-week period – two online and four in-person – which were attended by 71 people. In addition, six VCFSE (voluntary, community, faith and social enterprise) organisations were commissioned to carry out additional activity, aimed at improving the reach of the engagement - particularly amongst under-represented groups - by utilising existing community channels and networks.

Projects included a focus on pregnant women, mums, parents and families; those who are experiencing or have experienced homelessness, the South Asian community; and Syrian, Yemeni, Somali, and Kurdish communities. Engagement materials were translated into 16 alternative languages to support this activity.

A targeted social media campaign on Instagram and Facebook generated 5,718 click-throughs to the programme website and achieved an approximate reach (the estimated number of people who saw the content) of 237,566.

The engagement findings were analysed and set out in a report – available at www.GynaeandMaternityLiverpool.nhs.uk – and the feedback will now inform the next stage of the programme, including the options process, which will also involve Lived Experience Panel members.

Shaping Care Together
The Shaping Care Together programme is looking at how urgent and emergency care services are offered across Southport, Formby and West Lancashire. In July 2024, NHS Cheshire and Merseyside ICB, NHS Lancashire and South Cumbria ICB and Mersey and West Lancashire NHS Teaching Hospitals Trust, held a public engagement to gather people's views on a case for change about these services.

There were a number of ways for people to get involved, including completing a questionnaire, or taking part in a public meeting or focus group. To help boost awareness and participation, a communications campaign blended digital and offline channels, while making use of use of local radio and newspaper advertising, social media and email marketing, as well as posters, leaflets and digital information screens across hospital sites. Healthwatch partners, along with voluntary and community groups and local elected representatives were also key to helping raise awareness and driving participation.

The engagement generated a high level of response, receiving nearly 3,000 questionnaire responses, more than 11,000 website visits, and more than 600 live stakeholder conversations, with feedback showing strong support for the ambitions put forward in the case for change. The insights gained were used to help develop a long list of possible options for services, which were then assessed in an options appraisal process.

A detailed report into the engagement, and further details of next steps and how to keep involved, are available at: https://yoursayshapingcaretogether.co.uk/you-said-we-did.

Gluten free prescribing
Gluten free products are sometimes prescribed to individuals who suffer from coeliac disease. As the successor body to nine former clinical commissioning groups (CCGs), NHS Cheshire and Merseyside inherited each CCG's commissioning policies, including those for gluten free prescribing. This means that there is currently variation in access to prescriptions for gluten free products.

Between 28th January and 11th March 2025, NHS Cheshire and Merseyside held a public consultation on a proposal to stop making gluten free bread and bread mixes

available on prescription. The consultation invited people to comment on the proposal, and share details of any impact that the potential changes might have for them.

More than 1,000 people responded to the consultation, and at the time of writing, analysis of the findings was underway. The feedback will be used in final decision-making about the proposal, which is expected to take place at the end of May 2025.

Clinical policy harmonisation
In January 2025, as part of the third phase of NHS Cheshire and Merseyside's policy harmonisation process, people were invited to share their views on 25 clinical policies. These policies cover some specific treatments and procedures, and set out when they should be used, and which patients would benefit medically from them. The process aims to remove any variation that exists between different areas, and ensure policies meet the most up-to-date medical evidence, guidance and best practice. In total, 116 people responded to the online questionnaire about the 25 policies in phase three. Feedback received will be used to inform the final updated versions.

Long COVID services
During February and March 2025, NHS Cheshire and Merseyside asked for people's views as part of a review of long COVID support.

Hub-based services for those experiencing longer-lasting effects from COVID-19 were put in place during 2020, with access via GPs, but the number of people using them has fallen significantly. With hub arrangements now ending, the NHS is looking at the best way to provide this care in the future, and the feedback received will be used to help develop plans for how services might look in the future. At the time of writing, nearly 500 people had completed a questionnaire as part of the engagement, with separate discussions also taking place with patient groups.

Community Voices
In October 2022, NHS Cheshire and Merseyside established a Citizens' Panel, on online group designed to gather insights about peoples' views and experiences. During 2024-2025 the group was rebranded as Community Voices, retaining the same aim of harnessing insights from our local population, but with a streamlined sign-up process to encourage greater participation. The group's membership of around 450 people continues to provide a consistently high response to questionnaires on a range of issues.

Supporting engagement about changes to GP services
Where there are proposed changes to the way that individual GP practice services are delivered, NHS Cheshire and Merseyside's communications and engagement team provides advice and support about involving patients.

During autumn 2024, NHS Cheshire and Merseyside invited patients registered with Lincoln House Surgery in Ainsdale and Birkdale locality, Sefton, to share feedback about the closure of the practice. People could provide their comments by email, phone or post, or at two drop-in sessions held at the surgery. The engagement activity took place between 19th August and 15th September 2024.

Harnessing patient voice in general practice
As the place where so many of us access NHS services, general practice presents a great opportunity for engagement, but skills and capacity to support this can be limited. During 2024 we worked with GP practices and primary care networks on a piece of work aimed at building knowledge and confidence in utilising patient voice. We also wanted to encourage practice teams to routinely share best practice and learning, so that others can learn from the great public involvement already taking place.

A series of sessions were held for both primary care networks and practices, focussed on the benefits of involving people and communities. Alongside this, NHS Cheshire and Merseyside developed a toolkit for running patient participation groups, which provided ideas for setting up new groups, and developing existing ones. To help embed the work and allow learning to continue, a network was created for primary care network and practice staff who had taken part, and NHS Cheshire and Merseyside has continued to utilise this for sharing information about relevant engagement opportunities.

Change NHS
In October 2024, the government launched Change NHS, to hear views, experiences and ideas from the public, patients and stakeholders, which will shape a new 10-Year Health Plan for England.

To increase participation from local groups who might be harder to reach, NHS Cheshire and Merseyside commissioned a separate piece of work, coordinated through Voluntary Sector North West, which delivered a number of specific, targeted sessions. A range of groups were involved in this work, including people experiencing homelessness, those living with long term conditions, people using drug and alcohol services, and those accessing the justice system.

Case Study – Change NHS engagement opportunities

Members of NHS Cheshire and Merseyside's Cheshire East Place team represented the Integrated Care Board at five public engagement opportunities co-ordinated by Congleton MP Sarah Russell in February 2025.

Centred around the NHS Ten Year Plan, the sessions invited residents to voice their opinions on the health service and what the three big shifts (Digital to Analogue, Hospital to Community and Sickness to Prevention) mean to them.

Structured to be accessible – with both in-person and online opportunities – the sessions invited residents to voice their opinions on the health service.

Residents felt passionately about the NHS and praised the efforts of staff across General Practice, pharmacy, community services and hospital Trusts, however they also felt there was much improvement needed – particularly regarding timely and efficient communication about appointments, joining up cross-border care and improving nutrition in hospitals.

1.2.7 Equality, diversity and inclusion

Discrimination against people with protected characteristics contributes to negative, disparate outcomes for patients. It is therefore vital that equality considerations are central to how we commission services and address health inequalities.

Legal context
The Public Sector Equality Duty (PSED) set out in the Equality Act 2010 requires public authorities in the exercise of their functions:

- to eliminate unlawful discrimination, harassment and victimisation
- to advance equality of opportunity between people who share a protected characteristic and those who do not and
- to foster good relations between people who share a protected characteristic and those who do not.

The protected characteristics include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Actions on equality requires:

- removing or minimising disadvantages suffered by people due to their protected characteristics
- taking steps to meet the needs of people from protected groups where these are different from the needs of other people and
- encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Strategic Equality Diversity and Inclusion (EDI) leadership sits within the central NHS Cheshire and Merseyside Director and Senior Leadership Structures. The Chief People Officer acts as the Senior Responsible Officer for EDI, Workforce and Organisational Development at Board-level. From a patient and commissioning perspective, the Senior Responsible Officer for EDI is the Assistant Chief Executive. The Associate Director of EDI provides strategic leadership across the organisation.

To support NHS Cheshire and Merseyside to evidence how it is meeting its PSED and its specific duties, the ICB will produce Annual Equality, Diversity and Inclusion annual report (2024-2025), which will provide a:

- summary of how equality of service delivery to different groups has been promoted through the organisation.
- equality information relating to our workforce and patients including customer satisfaction scores broken down by protected characteristics.
- performance against equality of service delivery systems (EDS) implementation.
- activities undertaken to promote and improve equality of service delivery.
- equality information.

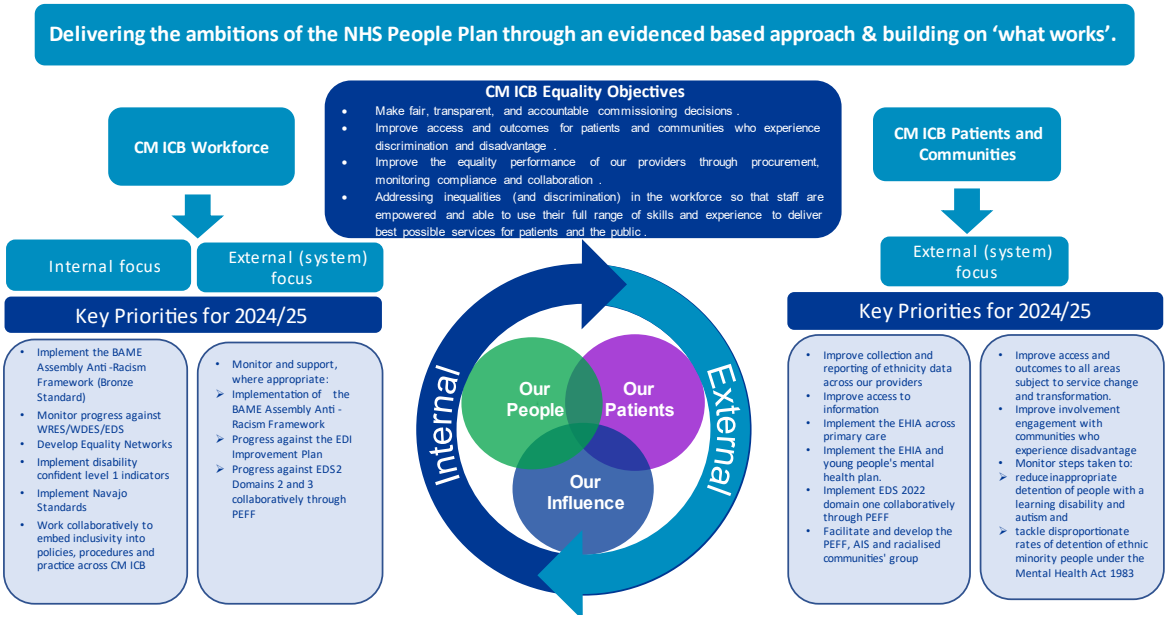
This report is due to be published in August 2025.

Equality Objectives (2024-2027) to support the organisation to meet priorities as its role as a leader, employer and a commissioner are to:

- make fair, transparent, and accountable commissioning decisions.
- improve access and outcomes for patients and communities who experience discrimination and disadvantage.
- improve the equality performance of our providers through procurement, monitoring compliance and collaboration.
- addressing inequalities (and discrimination) in the workforce so that staff are empowered and able to use their full range of skills and experience to deliver best possible services for patients and the public.

To support us with our equality objectives and priorities, we have developed an EDI Plan on a page (Figure 27). This plan is aligned to NHS Cheshire and Merseyside priorities and strategies including the All Together fairer strategy, the Cheshire and Merseyside Health and Care Partnership All Together Fairer strategy and the ICB Joint Forward Plan.

Figure 27 **Working towards greater patient and workforce equity outcomes 2024-25**



Key headline information that highlights improvements and progress against our Equality Objectives includes:

- **NHS Cheshire and Merseyside commitment to be a anti racist organisation and implement the North West anti racism framework**
- **Individual Funding Request Panel** - Individual Funding Requests (IFR) are made by GPs on behalf of patients in cases where additional funding may be required for an additional element to health care. These may include physical adaptations or aids, communication aids or further courses of clinical treatment, An Equality and Inclusion officer participates in the panel meetings and gives advice on cases whereby the Public Sector Equality Duty may be applicable. This process ensures that any individual case that is exceptional or unusual is duly considered and that decisions consider equality and inclusion and reasonable adjustments.

- **EDI Awareness Campaigns** - Working as part of a Communications team, a campaigns group was established in 2024. We moved away from monthly briefing to create a comprehensive annual EDI calendar which highlights all key events, awareness days, religious holidays and health initiates. Key campaigns over the past year have been International Women's Day, LGBT History month, Carers Week and other items including, Mental Health Awareness campaigns, religious festivals, Disability campaigns and anti-racism initiatives.
- **Equality Impact Assessments** - NHS Cheshire and Merseyside carries out Equality and Health Inequality Risk and Impact Assessments on all service changes and improvements, restructures, workforce and clinical policies, and strategies. The EDI officers complete and review these assessments and offer advice and support across the organisation to ensure these are of a high standard and fit for purpose. Over the past year, we have carried out over 100 EIAs including Human Resource policies, clinical policies, Financial Recovery Programme Initiatives Many of the clinical policies underwent public consultation and we use this information to inform the EIAs, which, in turn, inform our decision-making processes. Furthermore, our EIA process will be reviewed and strengthened this year to support our robust commissioning role.
- **Monitoring of Providers** - all 16 NHS Provider Trusts in Cheshire and Merseyside are monitored and audited for compliance around statutory and regulatory mandated standards.
- **NHS Cheshire and Merseyside Equality Collaborative forum -** The collaborative (formally known as the Patient Equality Focused Forum) is made up of equality leads and key officers from across the healthcare system. This group works collaboratively to share best practice, identify issues to collaborate on, and provide recommended actions to their respective organisations to advance equality of opportunity and support NHS Cheshire and Merseyside to address health inequalities and barriers in accessing healthcare services to improve patient journey and experience
- **Established Accessible information Standard Partnership.** This aims to improve how NHS services (in primary care and secondary care) and Sefton MBC Social Services implement the standard.
- **Community focussed racialised community group.** Aims to support commissioners to improve access and outcomes for racially marginalised patients only met once due to limited capacity and resource.
- **Ethnicity and inclusion data advisory group.** Aims to improve ethnicity data recording and data quality across the system. Work has taken place with lead commissioners, and Provider informatic specialists which will result in all our secondary care Providers being monitored via the Quality contract schedule for the next two financial years.

Equality Delivery System 2022 (EDS 2022)

The EDS is the foundation of equality improvement within the NHS. It is an accountable improvement tool for NHS organisations in England - in active conversations with patients, public, staff, staff networks and trade unions - to review and develop their services, workforces, and leadership. It is driven by evidence and insight.

The EDS provides a focus for organisations to assess the physical impact of discrimination, stress, and inequality, providing an opportunity for organisations to support a healthier and happier workforce, which will in turn increase the quality of care provided for patients and service users. EDS 2022 comprises eleven outcomes spread across three domains, which are:

Domain One: Commissioned or provided services
1A: Service users have required levels of access to the service
1B: Individual service user's health needs are met
1C: When service users use the service, they are free from harm
1D: Service users report positive experiences of the service

Domain Two: Workforce health and wellbeing
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions (response to Covid-19)
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source
2C: Staff have access to support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source (response to Covid-19)
2D: Staff recommend the organisation as a place to work and receive treatment

Domain Three: Inclusive leadership
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed
3C: Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients (response to Covid-19).

The outcomes are evaluated, scored, and rated using available evidence and insight. It is these ratings that provide assurance or point to the need for improvement. Scoring in conjunction with key stakeholders to determine if the organisation is graded as:

- Underdeveloped
- Developing
- Achieving
- Excelling.

The completion of the EDS, and the creation of interventions and actions plans in response to the EDS findings, can contribute to NHS system and provider organisations achieving delivery on the Core20Plus5 approach and Health Inequalities priorities.

Domain One implementation
NHS Cheshire and Merseyside and the 16 NHS Provider Trusts within Cheshire and Merseyside implemented EDS 2022 for the 2024 -2025 period. For Domain One, NHS Cheshire and Merseyside asked each Trusts equality / patient experience lead to liaise with executive colleagues of their respective organisation to identify services to review. Cheshire and Merseyside ratings for Domain One is **Achieving** across each outcome. This is the Mean rating, as taken from the all the NHS Trust's individual service review ratings (Table 10).

Table 10

Provider Trusts	**Domain One EDS grades 24/25**
Countess of Chester Hospital NHS Foundation Trust	**Score 8** **Achieving**
East Cheshire NHS Trust	**Score 8** **Achieving**
Liverpool University Hospitals NHS Foundation Trust	**Score 5** **Developing**
Liverpool Women's NHS Foundation Trust:	**Score 7** **Achieving**
Mid Cheshire Hospitals NHS Foundation Trust:	**Score 10** **Excelling/** **Achieving**
Mersey and West Lancashire Teaching Hospitals NHS Trust	**Score 9** **Achieving**
Warrington and Halton Hospitals NHS Foundation Trust:	**Score 8** **Achieving**
Wirral University Teaching Hospital NHS Foundation Trust:	**Score 8** **Achieving**
Mersey Care NHS Foundation Trust:	**Score 8** **Achieving**
Bridgewater Community Healthcare NHS Trust:	**Score 6** **Developing**
Wirral Community NHS Foundation Trust:	**Score 10** **Excelling /** **Achieving**
Alder Hey Children's Hospitals NHS Foundation Trust	**Score 8** **Achieving**
Liverpool Heart and Chest NHS Foundation Trust	**Score 8** **Achieving**
The Clatterbridge Cancer Centre NHS Foundation Trust	**Score 8** **Achieving**
The Walton Centre NHS Foundation Trust	**Score 8** **Achieving**
Cheshire and Wirral Partnership FT	**Score 8** **Achieving**
Total Mean C&M ICB	**Score 7.9** **Achieving**

EDS actions and areas for improvement will be reviewed and prioritised.

1.2.8 Emergency Preparedness, Resilience and Response

NHS Cheshire and Merseyside is classified as a Category 1 responder under the Civil Contingencies Act (2004) and subject to the following civil protection duties:

- assess the risk of emergencies occurring and use this to inform all together;
- put in place emergency plans;
- put in place business continuity management arrangements;
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- share information with other local responders to enhance coordination; and
- cooperate with other local responders to enhance coordination and efficiency.

Emergency Preparedness, Resilience and Response is a core function of the NHS and is a statutory requirement of the Civil Contingencies Act (2004). Responding to emergencies is also a key function within the NHS Act (2005) as amended by the Health and Social Care Act (2012).

During 2024-2025, the ICB Director of Performance and Planning was - and continues to be - the organisation's Accountable Emergency Officer, supported by the Head of Emergency Preparedness, Resilience and Response. In order to meet its statutory duties as a Category 1 responder, NHS Cheshire and Merseyside holds a portfolio of emergency and business continuity plans developed in consultation with corporate teams, Places and key stakeholders.

As per the Emergency Preparedness Resilience and Response Framework (2022), a self-assessment was performed by NHS Cheshire and Merseyside against the Emergency Preparedness, Resilience and Response Core Standards in September 2024. Partial compliance was declared, with only 6 out of 47 standards requiring further action to meet full compliance. This was a significant improvement on the 2023 rating of non-compliance with 28 out of 47 requiring further action.

The Emergency Preparedness Resilience and Response Team supported Tactical and Strategic Commanders in the use of prepared plans to effectively respond to and recover from a range of incidents during 2024-2025:

Amber Rain Alert	May 2024
M62 Road Traffic Collision	July 2024
IT Outage	July 2024
Southport Stabbings and Protests	July 2024
Cyber incidents (various Trusts)	November 2024
Critical incident declarations due to operational pressures	January 2025

To help minimise disruption and support patient care across the system, an Incident Coordination Centre was activated on each occasion and a Command and Control Structure put in place. Debriefs were also undertaken following each incident to

highlight lessons and notable practice. Subsequent reports were shared with multi-agency partners where appropriate to inform the planning and response arrangements for potential future incident response.

The Emergency Preparedness, Resilience and Response team also performed a crucial role in the multi-agency planning arrangements for significant events across Cheshire and Merseyside during 2024-2025 which included:

Grand National	April 2024
Duke of Westminster wedding	June 2024
Taylor Swift Concerts	June 2024
Southport Airshow	July 2024
Creamfields	August 2024
Labour Party Conference	September 2024
HMS Prince of Wales	December 2024

With regards to training, NHS Cheshire and Merseyside developed and delivered four exercises and participated in 13 multi-agency exercises in 2024-2025 to test and validate local plans. These exercises also include for the first time, system-wide communications exercises, incorporating all Trusts across Cheshire and Merseyside, to test both the in hours and out of hours notification and cascade response for an incident. These had never been attempted before, were a resounding success and, as such, will now be repeated annually.

The Emergency Preparedness Resilience and Response Team have also delivered 26 EPRR specific training sessions in relation to Commander Training, Loggist Training and Resilience Direct Training. These sessions benefit Strategic Commanders, Tactical Commanders and EPRR Specialists within Cheshire and Merseyside. An additional 11 specific training sessions were also provided on specific areas including Legal Awareness, Structured Debriefing, Military Aid to the Civil Authorities and Military Awareness.

NHS Cheshire and Merseyside continue to lead the health sector in multi-agency preparedness and planning for emergencies, through the Local Health Resilience Partnership and are core members of both the Cheshire Resilience Forum and Merseyside Resilience Forum. The Local Resilience Forums identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities, for which NHS Cheshire and Merseyside represents the whole health sector and providers within Cheshire and Merseyside.

1.2.9 Research and Innovation

In line with NHS England's guidance on Maximising the Benefits of Research as well as our statutory responsibility to deliver research and innovation under the Health and Social Care act 2022 the Board of NHS Cheshire and Merseyside Board approved the establishment of an Integrated Research and Innovation System (IRIS) that aligns with both local and national research and innovation priorities.

IRIS adds value to our Cheshire and Merseyside health and care environment by attracting research investment, strongly supporting innovation and enabling the Integrated Care System to evolve into a world-class system of research and innovation excellence.

Recent successes include:

- University Hospital Liverpool Group (UHLG) has been awarded more than £5.6million via national funding to establish a NIHR Commercial Research Delivery Centre (CRDC) that will reach across the Cheshire and Merseyside Integrated Care system. The establishment of the CRDC will mean even more studies and treatments will be available in areas including cancer, respiratory illness, obesity and infectious diseases
- Cheshire and Merseyside has secured funding for Research Engagement Network (REN) programmes
- won a National Institute for Health Research Capital Investment Award for Mobile Research Units and Primary Care Research Hubs
- supported the development of award-winning collaborations such as the Wirral Research Collaborative
- collaboration with C2aI on surgical risk and pre-habilitation awarded best use of data in health innovation and overall innovation champion at the Health Innovation Network and NHS Confederation Innovation Awards
- promotion of primary care research achieving the largest recruitment in most deprived communities and total number of studies opened, and in the top three nationally for total primary care recruitment and commercial recruitment

Cheshire and Merseyside has a strong foundation in primary and community research, with 349 practices engaged, 131 actively recruiting, and 53 involved in commercial studies—more than twice the national average (15% vs 6%). The region ranks among the top three nationally for total primary care recruitment, alongside North West London and Oxford, and leads all ICBs for research recruitment in the most deprived communities. It also tops the country for the total number of primary care studies opened and for recruitment in the most deprived communities demonstrating its commitment to inclusive and impactful research.

NHS Cheshire and Merseyside Digital maturity

NHS Cheshire and Merseyside's Digital Team work with colleagues in Primary Care (General Practice) to oversee the procurement, implementation and optimisation of digital tools to enable the delivery of modern general practice. This includes tools such as Cloud-based telephony, online consultation, online registration, patient bookings and access to records as well as patient communication.

NHS Cheshire and Merseyside has developed a Digital sub strategy for Primary Care to oversee delivery of priority improvements and engages with primary care to support local transformation initiatives which increase digital maturity.

In 2024-2025, NHS Cheshire and Merseyside conducted a large-scale test of change (including objective independent evaluation) of a digital solution which has the potential advance digital maturity of primary care at practice level, enable services to be planned and delivered at Primary Care Network or locality level and

presents an innovative opportunity to seamlessly enable new models of neighbourhood working.

System-wide digital maturity
NHS Cheshire and Merseyside's Digital Team works collaboratively with Provider organisations to review digital maturity and support improvement plans, principally through the national Frontline Digitisation programme which will enable providers to procure and implement Electronic Patient records.

Through a Chief Information Officer network meeting, NHS Cheshire and Merseyside facilitates peer review arrangements and leads on several 'at scale' programmes contributing to advancement of digital maturity: Cyber Security; Automation; Digital Diagnostics.

The diagnostics programme has advanced digital maturity of both the imaging and pathology network with the deployment of a single cloud-hosted PACS solution for Cheshire and Merseyside and the deployment of a multi-Trust Pathology Laboratory solution across five hub organisations which will be the cornerstone for further transformation of the diagnostic operating model.

NHS Cheshire and Merseyside's Digital Team also led discussions in Liverpool Place to agree a converged Electronic Patient Record strategy and a roadmap to a converged application strategy across the city which will be a key enabler for the emerging University Hospitals of Liverpool Group across the city.

NHS Cheshire and Merseyside has also supported Mersey and West Lancashire Teaching Hospitals NHS Foundation Trust and Warrington and Halton Hospitals NHS Trust in developing a joint strategy for Electronic Patient Record procurement.

1.2.10 Financial Review

1.2.10.1 Statutory Duties

NHS Cheshire and Merseyside has a number of financial duties under the NHS Act 2006 (as amended) (Table 11):

Table 11: Financial Duties

Duty	Achieved
Expenditure not to exceed income	Yes
Capital resource use does not exceed the amount specified in Directions	Yes
Revenue resource use does not exceed the amount specified in Directions	Yes
Revenue administration resource use does not exceed the amount specified in Directions	Yes

NHS Cheshire and Merseyside achieved its financial duties in the year ended 31st March 2025.

1.2.10.2 Financial Performance

Table 12 summarises NHS Cheshire and Merseyside's financial performance for the year to 31st March 2025

Table 12

Area of Expenditure	2024-25		
	In Year Allocation **£000s**	**Expenditure** **£000s**	**Surplus/ (Deficit)** **£000s**
Programme	7,906,976	7,882,040	24,936
Running Costs	48,572	48,103	469
Total	**7,955,548**	**7,930,143**	**25,405**

Each year NHS Cheshire and Merseyside is given a spending allocation for programme costs and running costs and formulates its spending plan against the allocation. During the year, NHS Cheshire and Merseyside delivered a surplus (underspend) of £25.405m against its spending allocations in the year ended 31 March 2025.

On 1st April 2024, responsibility for commissioning certain specialised services transferred from NHS England to NHS Cheshire and Merseyside and this accounted for £618m of the increase in net expenditure from £6,702m in the year ended 31st March 2024 to £7,930m in the year ended 31st March 2025. Net programme expenditure, excluding specialised commissioning increased by £613m reflecting uplifts in funding for pay costs, increases in spend for the elective recovery and other NHS priorities.

£1.519m was spent on capital items in the year following a capital allocation of £1.519m. Capital expenditure principally consisted of renewals of leases for buildings capitalised as Right of Use assets, less disposals of leases no longer required. Lease arrangements are treated as capital items under accounting standards.

1.2.10.3 Financial Analysis

The analysis in Table 13 provides further information on NHS Cheshire and Merseyside's net expenditure for the year ended 31st March 2025.

Table 13

Expenditure Area	2024/25 £000s
Acute Provision	3,767,401
Community Services	706,378
Primary Care Other	103,218
Prescribing incl. Associated Costs	564,036
Primary Care Delegated	861,578
Specialist Commissioning	618,013
Mental Health Services	746,108
Continuing Healthcare	435,370
Other	79,938
Total Programme Expenditure	**7,882,040**
Running costs	48,103
Total Expenditure	**7,930,143**

Figure 28 shows the relative percentage of NHS Cheshire and Merseyside expenditure against the reporting categories.

Figure 28 ICB Expenditure Split by Percentage

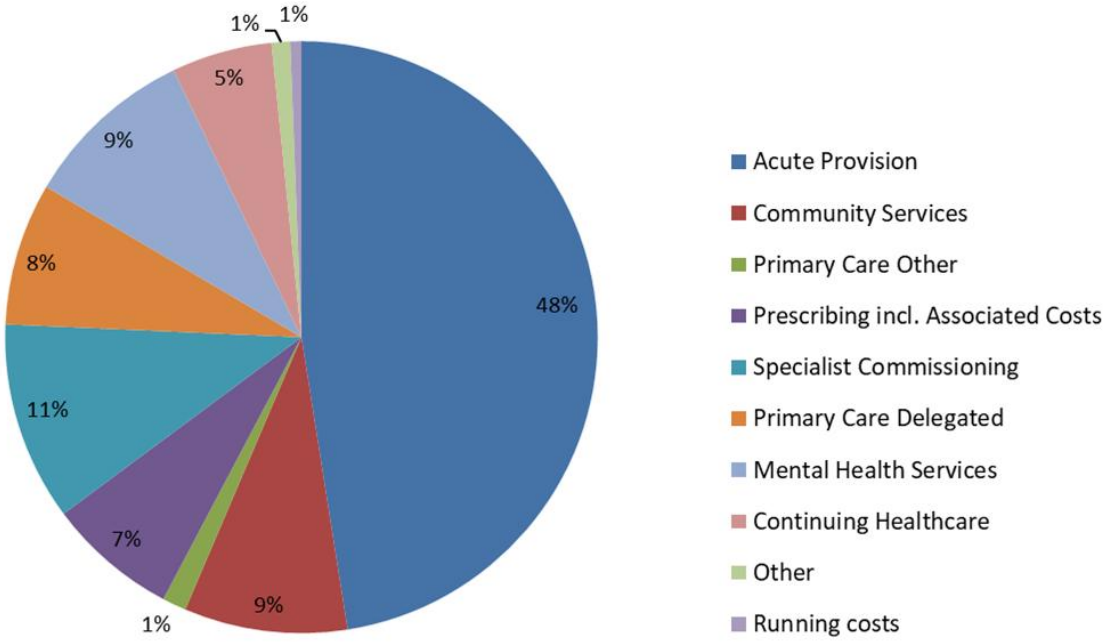


Table 14 provides information on NHS Cheshire and Merseyside's programme expenditure with the top 15 NHS providers for the year ended 31st March 2025. These providers account for £5.787bn or 73% of NHS Cheshire and Merseyside Programme expenditure.

Table 14

Provider	£000s
Liverpool University Hospital NHS Foundation Trust	1,150,287
Mersey & West Lancashire Teaching Hospitals NHS Trust	814,382
Mersey Care NHS Foundation Trust	590,459
Wirral University Teaching Hospital NHS Foundation Trust	558,788
Mid Cheshire NHS Foundation Trust	454,212
Warrington NHS Foundation Trust	398,598
Countess of Chester Hospital NHS Foundation Trust	368,467
Cheshire and Wirral Partnership NHS Foundation Trust	255,373
Alder Hey Children's NHS Foundation Trust	246,539
East Cheshire NHS Foundation Trust	220,368
North West Ambulance Service NHS Trust	186,858
Liverpool Women's NHS Foundation Trust	168,636
Clatterbridge Cancer Centre NHS Foundation Trust	142,289
Liverpool Heart and Chest Hospital NHS Foundation Trust	123,176
Walton centre NHS Foundation Trust	108,915
Total Programme Expenditure Top 15 NHS providers	**5,787,346**
Other Programme Net Expenditure	2,094,694
Total Programme Expenditure	**7,882,040**
Running costs	48,103
Total Net Expenditure for the Year	**7,930,143**

1.2.11.5 Mental Health

The percentage of mental health spend (as defined by the Mental Health Investment Standard) as a proportion of overall programme spend can be seen in Table 15.

Table 15

	2024/25	2023/24
	£'000	£'000
Mental Health Expenditure	591,031	544,876
NHS Cheshire and Merseyside Programme Allocations Excluding Delegated Services	7,906,976	5,833,410
Mental Health Spend as a proportion of NHS Cheshire and Merseyside Programme Allocation	7%	9%

Graham Urwin

Graham Urwin
Chief Executive (01 July 2022 – 31 May 2025)
19 June 2025

Cathy Elliott

Cathy Elliot
Chief Executive (01 June 2025 -)
19 June 2025

Accountability Report

- Corporate Governance Report
- Remuneration and Staff Report
- Parliamentary Accountability and Audit Report

2. Accountability Report

2.1 Accountability Report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1st April 2024 to 31stMarch 2025, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

2.2 Corporate Governance Report

2.2.1 Members Report

2.2.1.1 Chair and Chief Executive

Raj Jain is the Chair of NHS Cheshire and Merseyside and has been in post since 1st July 2022. Graham Urwin was the Chief Executive from 1st July 2022 until 31st May 2025, with Cathy Elliott becoming Chief Executive on 1st June 2025.

2.2.1.2 Board

The Board of NHS Cheshire and Merseyside directs and controls the major activities of the organisation and is collectively accountable for the performance of its functions.

The membership of the Board during 2024-2025 is set out in Table 16.

Table 16

Name	Position	From	To
Raj Jain	Chair	1 July 2022	Present
Tony Foy	Non-Executive Member	1 July 2022	Present
Erica Morriss	Non-Executive Member	1 July 2022	Present
Neil Large MBE	Non-Executive Member	1 July 2022	28 February 2025
Professor Hilary Garrett CBE	Non-Executive Member	18 January 2023	Present
Dr Ruth Hussey CB, OBE, DL	Non-Executive Member	1 November 2023	Present
Dr Naomi Rankin	Partner Member	1 January 2023	Present
Adam Irvine	Partner Member	1 July 2022	Present
Professor Stephen Broomhead MBE	Partner Member	1 July 2022	Present
Cllr Paul Cummins	Partner Member	1 July 2022	May 2024
Andrew Lewis	Partner Member	1 October 2024	Present
Ann Marr OBE	Partner Member	1 July 2022	Present
Professor Joe Rafferty CBE	Partner Member	1 July 2022	1 October 2024
Trish Bennett	Partner Member	1 November 2024	Present
Warren Escadale	Partner Member	1 October 2024	Present
Graham Urwin	Chief Executive	1 July 2022	Present
Claire Wilson	Executive Director of Finance	1 July 2022	8 December 2024
Mark Bakewell	Executive Director of Finance (Interim)	9 December 2024	Present
Professor Rowan Pritchard-Jones	Medical Director	1 July 2022	Present
Christine Douglas MBE	Executive Director of Nursing and Care	1 August 2022	Present

2.2.1.3 Directors

NHS Cheshire and Merseyside's directors, in addition to those on the Board listed 2.2.1.2, for the 2024-25 period are set out in Table 17.

Table 17

Corporate Directors			
Name	**Position**	**From**	**To**
Clare Watson	Assistant Chief Executive	1 July 2022	Present
Chris Samosa	Chief People Officer	1 July 2022	31 December 2024
Mike Gibney	Chief People Officer	13 January 2025	Present
Anthony Middleton	Director of Performance and Planning	1 July 2022	Present
Dr Fiona Lemmens	Deputy Medical Director	1 July 2022	Present

John Llewellyn	Chief Digital Officer	17 October 2022	Present

Place Directors			
Name	**Position**	**From**	**To**
Mark Wilkinson	Place Director – Cheshire East	1 July 2022	Present
Laura Marsh	Interim Place Director – Cheshire West	22 Nov 2023	Present
Anthony Leo	Place Director – Halton	1 July 2022	Present
Anthony Leo	Acting Place Director - Liverpool	18 December 2024	Present
Alison Lee	Place Director – Knowsley	1 July 2022	Present
Mark Bakewell	Place Director – Liverpool	06 Feb 2024	8 December 2024
Deborah Butcher	Place Director – Sefton	1 July 2022	Present
Mark Palethorpe	Place Director – St Helens	1 July 2022	Present
Carl Marsh	Place Director – Warrington	1 July 2022	Present
Simon Banks	Place Director – Wirral	1 July 2022	Present

Further information regarding NHS Cheshire and Merseyside's current Board members and directors can be found on our website.[11]

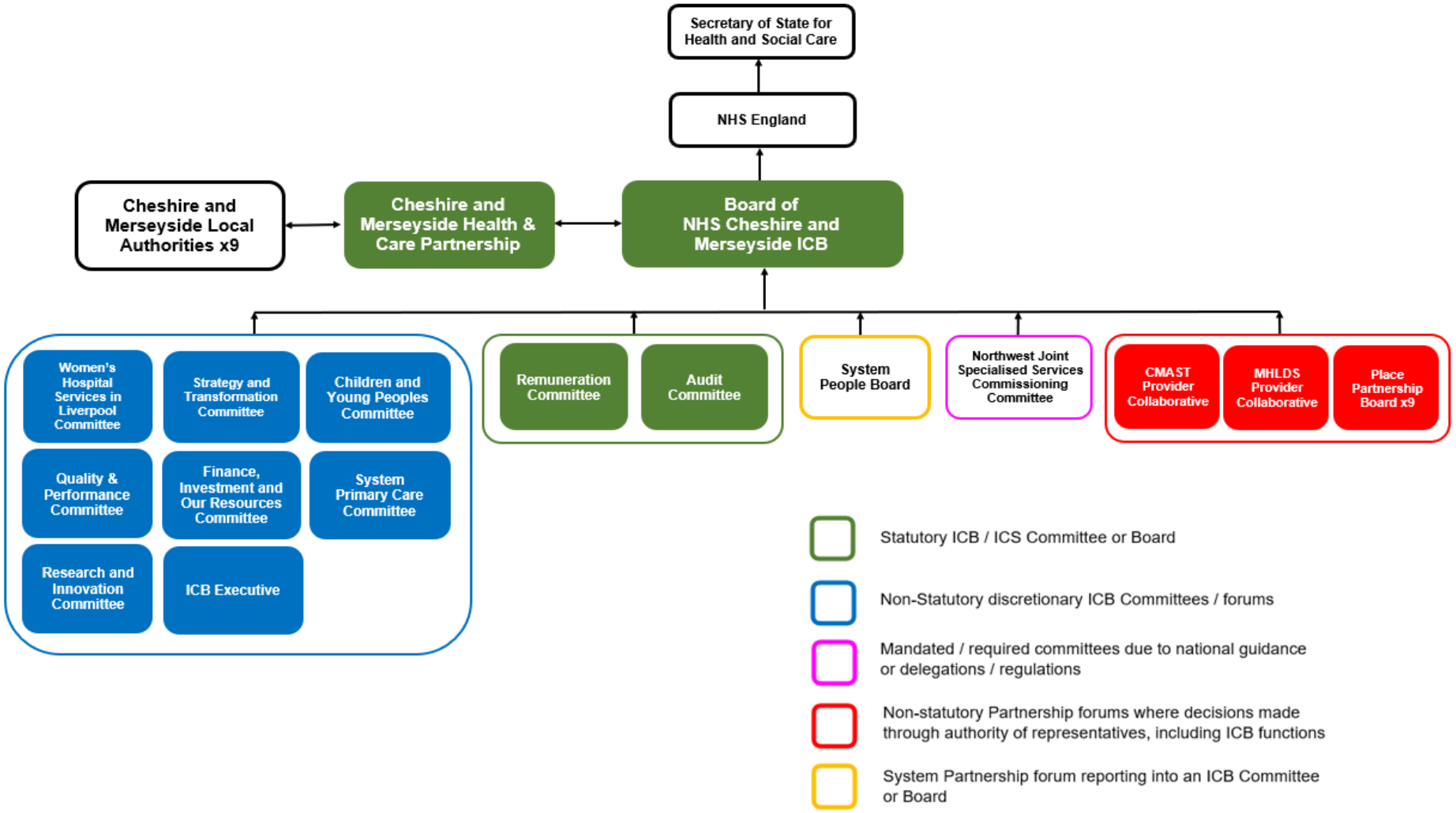
2.2.1.4 Committee(s), including Audit Committee

The members of the Audit Committee during the period covered by this report are set out in Appendix One.

NHS Cheshire and Merseyside's governance and committee structure is set out in Figure 29. The membership of, and attendance at each committee is provided in Appendix One.

[11] https://www.cheshireandmerseyside.nhs.uk/about/nhs-cheshire-and-merseyside/leadership-team/ (last checked on 14.06.24)

Figure 29: NHS Cheshire and Merseyside Integrated Care Board Governance and Committee Structure



2.2.1.5 Register of Interests

NHS Cheshire and Merseyside currently maintain three separate registers which are available on its public website:

- Declarations of Interests
- Gifts, Hospitality and Sponsorship
- Conflict of Interest Breaches Log.

These registers can be found on our website.[12]

NHS Cheshire and Merseyside has in place a Conflicts of Interest Policy which sets out the approach to managing conflicts of interest (including gifts, hospitality, and sponsorship), and has been approved by the Board. A copy of the policy can be found on our website.[13]

During 2024-2025 there were no reported breaches of the NHS Cheshire and Merseyside's Conflicts of Interest policy and procedures.

2.2.1.7 Personal data related incidents

NHS Cheshire and Merseyside's arrangement for information governance are described in the Governance Statement on page 122.

There were no personal data related incidents during the year which required formal reporting to the Information Commissioner's Office (ICO).

2.2.1.8 Modern Slavery Act

NHS Cheshire and Merseyside fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2025 is published on our website.[14]

2.2.2 Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS Cheshire and Merseyside and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer, is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
    - state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
    - prepare the accounts on a going concern basis; and

[12] https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/managing-conflicts-of-interest/ (last checked on 02.06.25)
[13] https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/managing-conflicts-of-interest/ (last checked on 02.06.25)
[14] https://www.cheshireandmerseyside.nhs.uk/about/equality-diversity-and-inclusion/modern-slavery-act-statement/ (last checked on 02.06.25)

- confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive to be the Accountable Officer of NHS Cheshire and Merseyside. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding NHS Cheshire and Merseyside's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Cheshire and Merseyside's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Graham Urwin

Graham Urwin
Chief Executive (01 July 2022 – 31 May 2025)
19 June 2025

Cathy Elliott

Cathy Elliot
Chief Executive (01 June 2025 -)
19 June 2025

2.2.3 Governance Statement

2.2.3.1 Introduction and context

NHS Cheshire and Merseyside is a body corporate established by NHS England on 01 July 2022 under the National Health Service Act 2006 (as amended).

NHS Cheshire and Merseyside's statutory functions are set out under the National Health Service Act 2006 (as amended).

NHS Cheshire and Merseyside's general function is arranging the provision of services for persons for the purposes of the health service in England. It is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1st April 2024 and 31st March 2025, NHS Cheshire and Merseyside was not subject to any directions from NHS England issued under Section 14Z61 of the National Health Service Act 2006 (as amended).

2.2.3.2 Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of NHS Cheshire and Merseyside's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the NHS Cheshire and Merseyside's Accountable Officer Appointment Letter.

I am responsible for ensuring that NHS Cheshire and Merseyside is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within NHS Cheshire and Merseyside as set out in this governance statement.

2.2.3.3 Governance arrangements and effectiveness

The main function of the Board of the ICB is to ensure that NHS Cheshire and Merseyside has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

NHS Cheshire and Merseyside's governance arrangements described below have been designed, developed and embedded to ensure that:

- through the membership of the Board, its committees and underpinning network of partnership, programme, clinical and other advisory networks, there is access to a broad range of professional expertise in the prevention, diagnosis or treatment of illness, and the protection or improvement of public health.
- it is appropriately informed and clear on the impacts of decisions, and responsive to the 'triple aims' of health and wellbeing of the people of England, quality of healthcare services for the purposes of the NHS and sustainable and efficient use of resources by NHS bodies.

The ICB constitution[15] commits NHS Cheshire and Merseyside to, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England. NHS Cheshire and Merseyside has agreed standards of business conduct. These set out the expected behaviours that members of the Board and its committees will uphold while undertaking NHS Cheshire and Merseyside business, and principles that will guide decision making.

The constitution commits NHS Cheshire and Merseyside to demonstrating its accountability to local people, stakeholders, and NHS England in a number of ways. These include a set of principles for involving people and communities, meetings and publications, the appointment of five non-executive members to the Board, transparent decision-making, compliance with procurement rules and the publication of an annual report and accounts.

The constitution describes the arrangements for the exercise of its functions, which may be through delegation internally, externally or jointly with another body, where permitted by legislation.

NHS Cheshire and Merseyside has published a functions and decision map,[16] which provides a high-level structural chart setting out which decisions are delegated and taken by which parts of the system.

NHS Cheshire and Merseyside has also published a scheme of reservation and delegation,[17] which sets out those decisions which are reserved to the Board and those which have been delegated.

NHS Cheshire and Merseyside's Governance Structure Chart is in the Members Report on page 105. Details of the membership and attendance at the Board and each of its committees is provided in Appendix One. The key responsibilities of the Board and each of its committees, highlights of their work, and assessment of their performance and effectiveness over the year is provided in sections 2.2.3.4 to 2.2.3.14.

2.2.3.4 Board of NHS Cheshire and Merseyside

NHS Cheshire and Merseyside sets out to use its resources and powers to achieve demonstrable progress against the four core purposes of Integrated Care Systems. These are as follows and are set by NHS England:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

The Board of NHS Cheshire and Merseyside remains accountable for all of the functions of the Integrated Care Board, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place forming part of agreed terms of delegation. Each NHS Cheshire and Merseyside committee provides a frequent assurance update to the Board on the areas it has considered

[15] https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/constitution/ (last checked on 02.06.25)
[16] https://www.cheshireandmerseyside.nhs.uk/media/gkikz0x5/functions-and-decisions-map.pdf (last checked on 02.06.25)
[17] https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/ (last checked on 02.06.25)

and which are within the scope and authority of each respective committee terms of reference.

During 2024-2025, the Board has held its meetings in public seven times and was quorate on each occasion. Key activities of the Board included the approval and oversight of NHS Cheshire and Merseyside's significant strategies, plans and financial plan / budget; making decisions in relation to major change programmes such as Shaping Care Together and Gynaecology and Maternity Hospital Services in Liverpool; making decisions in relation to items reserved to the Board; and receiving assurance reports in relation to key strategic issues and risks from committees and leadership.

2.2.3.5 Audit Committee

The Audit Committee is accountable to the Board and provides an independent and objective view of NHS Cheshire and Merseyside's compliance with its statutory responsibilities. The Committee is responsible for arranging appropriate internal and external audit.

The Committee provides oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within NHS Cheshire and Merseyside.

During 2024-2025, the Committee has met seven times and was quorate on each occasion. Key activities of the Committee included scrutinising and recommending to Board NHS Cheshire and Merseyside's Annual Report and Accounts and receiving associated audit opinions and reports; approving policies where delegated to the committee; and oversight and assurance to the Board in relation to audit activity, anti-fraud, conflicts of interest, risk management, information governance, procurement waivers and freedom to speak up.

2.2.3.6 Remuneration Committee

The Remuneration Committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to NHS Cheshire and Merseyside.

During 2024-2025, the Committee has met six times and was quorate on each occasion. Key activities of the Committee included approving contractual changes in respect of very senior manager roles; approving recruitment arrangements and appointments to the NHS Cheshire and Merseyside Board and executive roles; approving policies where delegated to the committee; and receiving reports on very senior manager appraisals.

2.2.3.7 Integrated Care Board Executive Committee

The NHS Cheshire and Merseyside Executive Team Committee is responsible for effective operational management of NHS Cheshire and Merseyside, through the provision of effective leadership and direction to the work of the organisation. It also supports the Board in setting the vision and the organisations' strategic objectives.

In addition, the NHS Cheshire and Merseyside Executive Team Committee will provide direction, as a category one responder and that NHS Cheshire and Merseyside supports its partners with system and borough-wide planning and

activity. It will also make decisions in respect of system quality innovation productivity and prevention (QIPP) and financial recovery, any such decision shall be reported to the next meeting of the Board for ratification.

During 2024-2025, the Committee has met weekly. Key activities of the Committee included approving commissioning, decommissioning and funding decisions as delegated by the Board, reviewing and endorsing significant strategies, plans and financial plan / budget prior to submission for Board approval; and oversight and assurance to the Board in respect of key strategic programmes and activity of NHS Cheshire and Merseyside, finance, performance, quality, workforce, key issues and risks.

2.2.3.8 Finance, Investment and Our Resources Committee (FIRC)

The Finance, Investment and Our Resources Committee (FIRC) provides NHS Cheshire and Merseyside with a vehicle to support assurance, risk management, system engagement, delivery and collaborative resolution in finance and investment, including capital and resources, for NHS Cheshire and Merseyside as an employer.

During 2024-2025, the Committee has met ten times and was quorate on each occasion. Key activities of the Committee included decisions on budgets, capital plan and financial plan submissions, and procurements; endorsing the Infrastructure Strategy prior to Board approval; and oversight and assurance to the Board in respect of the long-term financial strategy, ongoing financial position, recovery programmes and delivery of efficiencies, procurement and risks.

2.2.3.9 Quality and Performance Committee

The Quality and Performance Committee provides the Board with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centred, well-led, sustainable and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021.

The Committee scrutinises the robustness of, and gains and provides assurance to the Board, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care. The Committee focuses on quality performance data and information and considers the levels of assurance that NHS Cheshire and Merseyside can take from performance oversight arrangements within the Integrated Care System and actions to address any performance issues.

During 2024-2025, the Committee has met twelve times and was quorate on each occasion. Key activities of the Committee included oversight and assurance to the Board in relation to the quality and performance of the range of services commissioned by NHS Cheshire and Merseyside, the SEND, All Age Continuing Care Programme and Safeguarding functions of NHS Cheshire and Merseyside, quality issues and concerns, patient safety incidents, complaints and risks; and approving policies where delegated by the Board.

2.2.3.10 System Primary Care Committee

The System Primary Care Committee has been established to enable collective decision-making on the review, planning and procurement of primary care services in

relation to GP primary medical services, community pharmacy, primary dental and primary ophthalmic services as part of NHS Cheshire and Merseyside's statutory commissioning responsibilities across Cheshire and Merseyside under delegated authority from NHS England.

During 2024-2025, the System Primary Care Committee has met six times and was quorate on each occasion. Key activities of the Committee included oversight and assurance to the Board in relation to delivery of primary care strategies and access improvement plans; response to national commissioning and contract policy, local system pressures, GP Patient Survey and Healthwatch reports on access improvement and patient experience.

2.2.3.11 Strategy and Transformation Committee

The Strategy and Transformation Committee has been established to support NHS Cheshire and Merseyside in the delivery of its statutory duties and provide assurance to the Board in relation to the delivery of strategy in alignment of those duties.

The purpose of the Committee is to ensure a leadership forum is in place to consider the development and implementation of the commissioning strategy and policy of NHS Cheshire and Merseyside in securing continuous improvement of the quality of services. It also ensures alignment of system programmes and referral of issues for clinical consideration, while ensuring that health inequalities and improved outcomes are continuously considered.

With effect from 1st April 2024, it also became the decision-making committee of NHS Cheshire and Merseyside in relation to delegation from NHS England of some specialised commissioning services activity.

During 2024-2025, the Strategy and Transformation Committee has met four times and was quorate on each occasion. Key activities of the Committee included approving transformation funding, arrangements for developing commissioning intentions, oversight of specialised commissioning and individual funding requests; approving policies where delegated to the Committee; and oversight and assurance to Board in relation to the development of key strategic plans, delivery of strategic transformation programmes and work programmes, and risks.

2.2.3.12 Women's Hospital Services in Liverpool Committee

The Women's Hospital Services in Liverpool Committee was established, following the Liverpool Clinical Services Review report published in January 2023, to oversee a programme of work to address the clinical sustainability of hospital services for women and the clinical risk in the current model of care.

Over the next five years, the Committee will oversee and assure the development and implementation of a future care model that will ensure that women's hospital services delivered in Liverpool provide the best possible care and experience for all women, babies, and their families. The scope will include tertiary services for Cheshire and Merseyside and proposed solutions may therefore impact on the care of patients across Cheshire and Merseyside and beyond and these populations will be fully considered in the programme.

During 2024-2025, the Committee has met four times and was quorate on each occasion. Key activities of the Committee included approving programme plans; endorsing the draft case for change; and oversight and assurance in relation to the delivery of the programme, stakeholder engagement and risks.

2.2.3.13 Children and Young People's Committee

The Children and Young People's Committee oversees, shapes and provides assurance to the Board of NHS Cheshire and Merseyside regarding its responsibilities and functions for children and young people (aged 0 to 25), children and young people with special educational needs and disabilities, and safeguarding (children and young people), including looked after children.

The Committee oversees the development and delivery of the Cheshire and Merseyside Children and Young People's Strategy and ensures effective system focus on Children and Young People as a population cohort. The Committee is also responsible for oversight of the delivery of the ambitions and priorities within the Cheshire and Merseyside Joint Forward Plan, in relation to Children and Young People.

During 2024-2025, the Committee has met five times and was quorate on each occasion. Key activities of the Committee included engagement with children and young people and relevant services; endorsing key strategies, plans and consultation responses; and considering reports on high risk, high-cost children and young peoples placements, the neurodiversity pathway and child poverty.

2.2.3.14 Cheshire and Merseyside Health and Care Partnership

The Cheshire and Merseyside Health and Care Partnership (HCP) is formally a joint Committee between NHS Cheshire and Merseyside and the nine Local Authorities of Cheshire and Merseyside. However, it is a broad alliance of a diverse range of organisations and representatives concerned with improving the care, health, and wellbeing of the population. Its meetings are jointly convened by local authorities and the NHS as equal partners in order to facilitate joint action to improve health and care outcomes and experiences, influence the wider determinants of health, and plan and deliver improved integrated health and care.

The HCP, as an Integrated Care Partnership, has a statutory responsibility to prepare, approve and publish an Integrated Care Strategy for the Cheshire and Merseyside Integrated Care System, setting out how the assessed needs in relation to Cheshire and Merseyside are to be met by the exercise of functions of the Integrated Care Board, NHS England, and the nine local authorities whose areas coincide with the Cheshire and Merseyside area.

During 2024-2025, the Health and Care Partnership has met five times and was quorate on each occasion. Key activities of the Health and Care Partnership included endorsing the the All together Fairer / Health and Care Partnership Annual Delivery Plan for 2024-2025 and the Population Health at Scale Programme and associated investment plans; and receiving reports on the voluntary, community, faith and social enterprise sector in Cheshire and Merseyside, child and family poverty in Cheshire and Merseyside, the Housing and Health Partnership launch, and the Cheshire and Merseyside Green Plan and work on sustainability across the system.

2.2.3.15 Joint Committees

Under s65Z5 of the act the ICB is able to jointly exercise its functions with other relevant bodies and in 2024.25 the ICB board has established two joint Committees.

2.2.3.16 North-West Specialised Services Joint Committee

Specialised services support people with a range of rare and complex conditions. They often involve treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions. The North-West was one of three regions in England where NHS England approved plans to delegate the commissioning of a number of specialised services, to ICBs from 1st April 2024. These arrangements are underpinned by a Delegation Agreement.

These services consist of 'delegate 1' services which are planned at a single-ICB level with decision being taken by the ICB, and 'delegate 2' services which are planned and commissioned jointly at a multi-ICB level.

In order to facilitate the delegate 2 decision making a Specialised Services Joint Committee has been established between the three North West ICBs (Cheshire and Merseyside, Greater Manchester, and Lancashire and South Cumbria). The Terms of Reference for the Joint Committee was approved by the Board of NHS Cheshire and Merseyside at its meeting in March 2024 and can be found on the ICB website at https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/.

The role of the Joint Committee is to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified Delegated Services as set out in the NHS England Delegation Agreement.

As a Joint Committee of the three ICBs, the Joint Committee is accountable to the respective Boards of NHS Cheshire and Merseyside ICB, NHS Greater Manchester ICB and NHS Lancashire and South Cumbria ICB.

The ICB has also established a Specialised Commissioning Oversight Group to oversee the commissioning and delivery of the 59 single-ICB Specialised (delegate 1) services that have been delegated from NHS England to NHS Cheshire and Merseyside from 1st April 2024. The group brings together the leadership of the ICB with the NHS England Nort West hub and subject matter experts with a commitment to ensure that we commission effective, high-quality care in relation to delegated specialised commissioning functions within the resources available.

2.2.3.17 Shaping Care Together Joint Committee

The Shaping Care Together programme is a health and care transformation programme operating across Southport, Formby and West Lancashire. Its aim is to improve the quality of care for local residents by exploring new ways of delivering services and utilising staff, money and buildings to maximum effect. A Case for Change detailing the current and future needs of the local population, the provision of local services and the key challenges facing the health and care system was approved by the Board of NHS Cheshire and Merseyside at its meeting in July 2024.

As the commissioners for the programme, NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria will be required to consider a Pre-Consultation

Business Case for approval in 2025 and to enable effective decision making, both Boards agreed to form a Joint Committee for future decisions in scope of the Shaping Care Together Programme. The Board of NHS Cheshire and Merseyside approved the Joint Committees Terms of Reference at its meeting November 2024, with the Committee Terms of Reference being available at: https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/.

As a Joint Committee of the two ICBs, the Joint Committee is ultimately accountable to the respective Boards of NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria. NHS Cheshire and Merseyside are the lead commissioner in this arrangement.

The Joint Committee is authorised to:

- receive and approve on behalf of both ICBs, any case for change for services within scope of the Shaping Care Together programme
- receive and approve on behalf of both ICBs, any Pre-consultation business cases and any associated capital strategic outline case for services within scope of the Shaping Care Together programme
- receive and approve on behalf of both ICBs any Outline Business Case or Full Business Case for services within scope of the Shaping Care Together programme
- receive and approve on behalf of both ICBs the associated materials involved with and the initiation of any engagement or formal consultations with the public, patients, carers and stakeholders, in respect of the services within the scope of the Shaping Care Together Programme
- receive, consider and decide on any further next steps after receiving the outcomes of any engagement or formal consultations with the public, patients, carers and stakeholders, in respect of the services within the scope of the Shaping Care Together Programme.

2.2.3.18 UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

2.2.3.19 Discharge of Statutory Functions

NHS Cheshire and Merseyside has reviewed all the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that NHS Cheshire and Merseyside is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of NHS Cheshire and Merseyside's statutory duties.

2.2.3.20 Risk management arrangements and effectiveness

NHS Cheshire and Merseyside's Risk Management Strategy sets out its statement of intent, organisational arrangements, systems and processes for risk management and assurance. It has been developed based on best practice and subject to consultation within NHS Cheshire and Merseyside and with its internal auditors.

Risks arise from a range of external and internal factors, and the identification of risks is the responsibility of all NHS Cheshire and Merseyside staff. This is done proactively, via regular planning and management activities and reactively, in response to inspections, alerts, incidents and complaints.

All risks are assessed to determine:

- a clear description identifying the cause, effect and impact on NHS Cheshire and Merseyside
- ownership of the risk including operational and executive leadership and overseeing committee
- strategic objective or function that will be impacted by the risk
- controls that are currently in place to mitigate the risk and an assessment of their effectiveness
- an evaluation of the impact and likelihood of the risk using NHS Cheshire and Merseyside's risk matrix to arrive at an inherent and current risk rating
- risk proximity indicating whether the impact will be immediate, within or beyond the current year
- appropriate risk treatment and further mitigation action based on risk tolerance and cost effectiveness
- sources of assurance in respect of key control measures.

The control framework and mechanisms aim to provide a holistic system for prevention, deterrence and management of risks including:

- governance structures, with clearly defined terms of reference, roles and explicit responsibilities for scrutiny and assurance
- an accountability and reporting framework, with clearly defined roles and responsibilities
- clear strategies and plans with associated monitoring and review mechanisms
- policies, procedures and guidance, supported by communication, training and development
- robust contracts and service level agreements and effective contract management processes
- robust and effective performance, financial, risk, and project management
- an internal control framework, including independent, external assurance.

During 2024-2025, the ICBs Internal Auditors as part of the Internal Audit Annual workplan, undertook a review of the ICBs risk management controls. Findings from the audit identified that there was a good system of internal controls operating at the ICB for risk management, and the ICB was provided with a substantial assurance rating. The ICB received two recommendations for improvement around training for staff and annual review of the ICB risk appetite statement.

The Board has developed and agreed the following core statement of risk appetite:

'NHS Cheshire and Merseyside's overall risk appetite is OPEN – we are willing to consider all delivery options and may accept higher levels of risk to achieve improved outcomes and benefits for patients.

NHS Cheshire and Merseyside has no tolerance for safety risks that could result in avoidable harm to patients.

Our ambitions to improve the health and wellbeing of our population and reduce inequalities can only be realised through an enduring collaborative effort across our system. We will not accept risks that could materially damage trust and relationships with our partners.

We will pursue innovation to achieve our transformational objectives and are willing to accept higher levels of risk which may lead to significant demonstrable benefits to our patients and stakeholders, while maintaining financial sustainability and efficient use of resources. We will support local system / providers to take risks in pursuit of these objectives within an appropriate accountability framework.'

NHS Cheshire and Merseyside has implemented a comprehensive strategy and robust processes for risk management. All of which can be found on a dedicated risk management section on the NHS Cheshire and Merseyside website.[18]

2.2.3.21 Capacity to Handle Risk

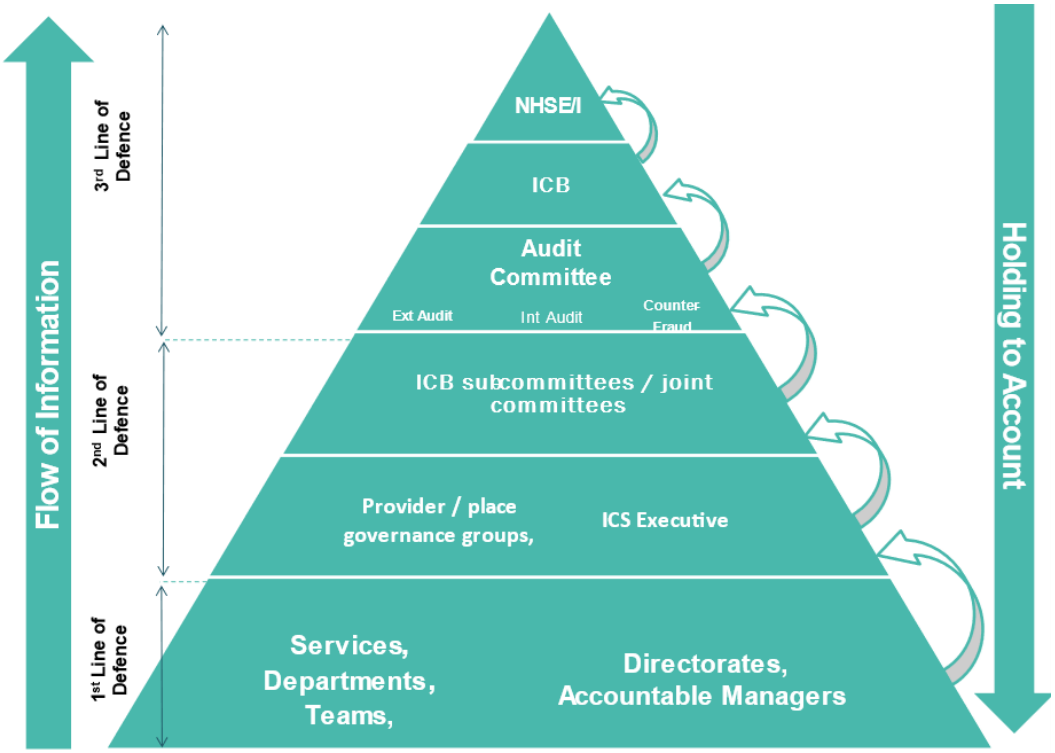
NHS Cheshire and Merseyside's Risk Management Strategy sets out specific accountabilities, roles and responsibilities for risk management and provides a structure that supports the integrated approach to risk and governance. These include the responsibilities of:

- the **Board** for providing the resources and support systems necessary and for assuring itself that the organisation has properly identified the risks it faces and has processes in place to mitigate those risks and the impact they have on the organisation and its stakeholders
- the **Audit Committee** for providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within NHS Cheshire and Merseyside
- all **committees and sub-committees** for providing assurance on key controls and ensuring that risks associated with their areas of responsibility are identified, reflected in the relevant corporate and / or place risk registers, and effectively managed
- NHS Cheshire and Merseyside's **governance lead** for the development and delivery of the Risk Management Strategy and associated operational procedures
- a **senior responsible lead** for each identified risk accountable to the Chief Executive, the relevant committee and the board for ensuring that the risk is appropriately managed.

NHS Cheshire and Merseyside's Risk Management Strategy incorporates the three lines of defence model as illustrated in Figure 30.

[18] https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/risk-management/ (last checked 02.06.25)

Figure 30



This includes:

- 1st line - Senior Responsible and Operational Leads have ownership, responsibility and accountability for directly assessing, controlling and mitigating risks.
- 2nd line - strategic leadership and oversight through the Board, its committees, place boards and reporting groups, leadership teams, and corporate monitoring and reporting activity.
- 3rd line - external review and oversight, including reporting, by auditors to the Audit Committee and the Board as appropriate, and supplemented through NHS England oversight and/or regulatory returns and reporting.

The Board Assurance Framework 2024-2025 was presented to the Board at its July 2024, November 2024, January 2025 and May 2025 meetings. The refreshed Board Assurance Framework for 2025-26 will be approved at the scheduled July 2025 meeting of the Board meeting for its approval.

The committees of the Board of NHS Cheshire and Merseyside receive quarterly risk reports for review and consideration of the level of assurance that can be provided to the Board. Their actions and conclusions are reported to the Board through committee highlight reports. Operational risks rated as extreme or critical are escalated to the Board through the quarterly Corporate Risk Register.

A risk management training programme was completed during 2023-24 and 2024-25, targeted at risk owners and senior risk leads across NHS Cheshire and Merseyside. In addition, guidance materials and resources, including signposting to expertise, support and advice across the organisation are available to all staff on the NHS Cheshire and Merseyside Staff Hub. Feedback from the training programme and through engagement with committee members, risk owners and governance leads have informed the review and update of the Risk Management Strategy and toolkit.

2.2.3.22 Risk Assessment

NHS Cheshire and Merseyside's Board Assurance Framework (BAF) identifies 10 principal risks to the delivery of NHS Cheshire and Merseyside's strategic objectives, the most significant of which are summarised in section 1.1.4 of the performance report. The 2024-2025 BAF is summarised in the heat map in Figure 31.

Figure 31

ID	Risk	Inherent			Current (Q3)			Target 2024-25			Risk Appetite (Optimal)	
		L	I	R	L	I	R	L	I	R	Rating	Timescale
P1	Health inequalities	4	5	**20**	3	5	**15**	3	5	**15**	High (8)	2027-28
P3	Elective care	5	5	**25**	3	5	**15**	3	5	**15**	Moderate (5)	2026-27
P4	Major quality failures	3	5	**15**	2	5	**10**	2	5	**10**	Moderate (5)	2026-27
P5	Urgent & emergency care	5	5	**25**	4	5	**20**	4	5	**20**	Moderate (5)	2026-27
P6	Primary care access	5	4	**20**	3	4	**12**	3	4	**12**	Moderate (6)	2025-26
P7	Statutory financial duties	5	5	**25**	4	4	**16**	4	4	**16**	High (8)	2026-27
P8	Provider sustainability	4	4	**16**	3	4	**12**	3	4	**12**	Moderate (6)	2026-27
P9	ICS workforce	4	4	**16**	4	4	**16**	4	4	**16**	Moderate (6)	2026-27
P10	Focus on long term strategy	4	4	**16**	3	3	**9**	3	3	**9**	Moderate (6)	2025-26
P11	Digital infrastructure	5	4	**20**	4	4	**16**	4	4	**16**	High (8)	2025-26

Risks to governance, risk management and internal control are summarised in Table 18. There are controls in place, including policies, processes, communications, training, information security systems and effective contracts and contract management in relation to commissioning support services. Assurance is provided through regular scrutiny and reporting at the Audit Committee and NHS Cheshire and Merseyside Executive Committee.

Future risks

The refreshed BAF for 2025-2026 will be approved at the scheduled July 2025 meeting of the Board meeting for its approval. It is anticipated that the updated BAF will be centred around the risks to the ICB achieving its key Annual Delivery Plan 2025-2026 priorities, namely:

- Financial Sustainability
- Urgent Care Improvement
- Planned Care
- Neighbourhood and Population Health.

It is also anticipated that there will be two additional BAF risks which will be centred around Safety (service safety and patient safety) as well as in relation to the robust management of ICB functions whilst the ICB progresses the model ICB blueprint priorities of transition of functions and staff, as well as reduction in ICB running costs.

The existing 2024-2025 ICB BAF risks will be reviewed and either reframed and incorporated into the refreshed BAF risks for 2025-2026, closed down or form part of the ICB Corporate Risk register.

Table 18

Risk	Risk Rating
Non-compliance with information governance policies leads to reportable data security and protection incident resulting in financial loss and / or reputational damage	**Moderate (6)**
Commissioning support or other data processors acting on NHS Cheshire and Merseyside's behalf breach statutory or regulatory requirements resulting in financial loss and / or reputational damage	**High (9)**
Business continuity incident impairs NHS Cheshire and Merseyside's ability to deliver statutory duties and functions resulting in reputational damage and / or financial loss	**High (8)**
Inconsistent adherence to core set of governance, financial and operational policies and procedures across NHS Cheshire and Merseyside leads to control failures, poor audit outcomes and reputational damage	**High (9)**
Incident arising from unsafe working practices or environment leads to death or injury for which NHS Cheshire and Merseyside is liable resulting in financial loss and / or reputational damage	**High (12)**
Major Incident causes disruption to NHS Cheshire and Merseyside and commissioned services	**High (10)**
Non-compliance with the public engagement framework may lead to a breach of the ICB's statutory duty to involve and consult resulting in financial penalties and reputational damage	**High (8)**
Ineffective public and patient involvement in the women's services programme could lead to challenge and / or failure to pass NHS England assurance processes	**High (12)**
NHS Patients - This risk area covers any fraud and corruption risks that are carried out by patients	**High (8)**

2.2.3.23 Internal Control Framework

A system of internal control is the set of processes and procedures in place in NHS Cheshire and Merseyside to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

NHS Cheshire and Merseyside's internal control framework comprises:

- the Board Assurance Framework, which is framed around NHS Cheshire and Merseyside's strategic objectives. This is reviewed and managed by NHS Cheshire and Merseyside's Executive Team and reported quarterly to the Board.
- an internal audit service commissioned from Mersey Internal Audit Agency (MIAA) and delivering a comprehensive and balanced audit plan which is approved and monitored by the Audit Committee. This provides an objective challenge and valuable insight into risks, control weaknesses and opportunities for improvement
- anti-fraud arrangements described in paragraph 2.2.3.32
- the governance framework described in paragraphs 2.2.3.3 to 2.2.3.17

- the NHS Cheshire and Merseyside Executive Team and Non-Executive Members
- the application of agreed policies and procedures, principally the corporate governance handbook including schemes of reservation and delegation and standing financial instructions.

This internal control framework is informed and assured by external scrutiny and review, including the NHS England System Oversight Framework and External Audit.

2.2.3.24 Data Quality

The importance of data quality is well recognised by NHS Cheshire and Merseyside and is critical in the production of accurate analysis which underpins and influences commissioning decisions, priorities, contractual performance and assurance activities. NHS Cheshire and Merseyside has specified the data requirements for both effective monitoring of the performance, quality and safety of commissioned services and to support its plans to redesign and re-commission services. These form the basis of regular reporting to NHS Cheshire and Merseyside, and its committees.

Data quality standards and requirements from commissioned providers are set out in information and quality contract schedules. The service agreements with NHS Cheshire and Merseyside's commissioning support providers include requirements for data validation and quality control.

NHS Cheshire and Merseyside has worked in partnership with its commissioning support providers to further develop the quality and design of reports and other business intelligence products. Performance data has been supplemented by intelligence from patient feedback, quality monitoring visits, audits, and contract monitoring activity to provide a broader view of performance than solely quantitative metrics.

The NHS Cheshire and Merseyside Business Intelligence team produces a routine data quality briefing report. This reviews the key contractual and performance data sets required to be submitted by providers either to meet national data requirements e.g., Secondary Users Services (SUS), Community Services Data Set (CSDS) or any local data requirements to support contracts e.g. SLAM. The monthly report includes the timeliness of data submissions, data quality, data validity e.g., a recent focus on the ethnicity coding to enable analysis to support targeted action to reduce health inequalities.

The report provides benchmarking of the national datasets against peers in addition to a regular overview of the Data Quality Maturity Index which provides an overview of data quality in the NHS by provider across the numerous data sets submitted. Actions to pick up on the findings from the report are led by the Business Intelligence team, through a departmental data quality logging process. This ensures known issues are identified and communicated appropriately, with actions assigned to key personnel to address them, including clear escalation routes to resolution. Resolution most commonly involves working with providers through the respective information subgroups, which form part of the contractual governance structure.

2.2.3.25 Information Governance

NHS Cheshire and Merseyside has a robust information governance framework, which includes:

- the roles of Senior Information Responsible Officer (SIRO), Caldicott Guardian, and the Information Governance Lead, who advise and support NHS Cheshire and Merseyside's Executive Team in relation to information governance matters
- the roles of Deputy SIRO and Deputy Caldicott Champion for each of our nine places, who advise and support place teams in relation to information governance matters
- the Information Governance Management Group whose purpose is to support and drive the broader Information Governance agenda and provide the Audit Committee, and ultimately the Board with assurance that effective IG is in place within the organisation
- an information governance handbook and code of conduct, data protection and security policy, supported by briefings and training for all Board members and staff, and resources on our Staff Hub
- an information asset register, and data flows map which record the nature and security arrangements for the data held and transmitted, including sensitive and confidential data, and the risks and security arrangements, which are regularly assessed and reviewed
- access to specialist expertise and advice, including scrutiny, challenge and spot checks, through commissioning support arrangements
- quarterly reports on compliance which are reported to the Audit Committee and an annual review by internal audit.

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to NHS Cheshire and Merseyside, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

NHS Cheshire and Merseyside completed the data security and protection toolkit (DSPT) self-assessment in 2023-2024 providing evidence to demonstrate that it meets the Data Security and Protection Standards for health and care relevant to Integrated Care Boards. The 2023-2024 DSPT audit conducted by Mersey Internal Audit Agency (MIAA) provided substantial assurance of NHS Cheshire and Merseyside's self-assessment and moderate assurance overall across all 10 standards. NHS Cheshire and Merseyside has an action plan to respond to the recommendations made by MIAA and will submit a further self-assessment for 2024-2025 at the end of June 2025.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures, and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

2.2.3.26 Business Critical Models

The data and intelligence provided through NHS Cheshire and Merseyside's commissioning support provider to inform needs analysis and service commissioning is subject to robust quality assurance both internally by the provider and by NHS Cheshire and Merseyside. NHS Cheshire and Merseyside's plans and forecasts are also subject to external scrutiny and sign-off by NHS England.

2.2.3.27 Third party assurances

NHS Cheshire and Merseyside relies on a number of third-party service provider organisations such as Capita (for primary care support / payments), NHS Shared Business Services Limited (for the provision of general ledger finance and accounting services - including invoice payment), Mersey and West Lancashire Teaching Hospitals NHS Trust (for payroll services), NHS Midlands and Lancashire Commissioning Support Unit (for Human Resources Support).

Typically, each area except for the Capita primary care support services and NHS Shared Business Services Limited, which are the responsibility of NHS England and Improvement, has a lead officer who maintains a client relationship with the service provider.

Those relations extend to regular contact and meetings with the providers, participation in client satisfaction ratings and where required intervention where performance falls below a satisfactory level. As appropriate, external standards and service delivery levels are monitored and by exception any assurance failings brought to the immediate attention of NHS Cheshire and Merseyside.

Assurance on these services is gained by independent service audits on the controls operated by these service providers which is commissioned directly by the contract holder, in most cases NHS England. NHS Cheshire and Merseyside reviews the independent audit reports for control issues at those service providers to assess whether there are adequate compensating controls to mitigate any risks to NHS Cheshire and Merseyside that might arise. After reviewing compensating controls operated by the NHS Cheshire and Merseyside, the issues identified in reports relating to the period to 31st March 2025 do not present a significant risk that would impact on NHS Cheshire and Merseyside directly.

2.2.3.28 Control Issues

A number of significant control issues in relation to quality and performance have or are impacting NHS Cheshire and Merseyside's achievement of priorities as follows:

- substantial progress made during the year towards the national ambition to eliminate long waits in excess of 65 weeks was offset by lost opportunities due to industrial action, cyber-attacks and urgent care pressures. In particular Mid Cheshire Hospitals NHS Foundation Trust experienced significant pressures within cardiology, rheumatology and trauma and orthopaedics. The Trust was

subject to additional oversight from both NHS Cheshire and Merseyside and NHS England, and was supported by the Provider Collaborative.

- significant demand, capacity and flow challenges in the urgent and emergency care system impacted on the ability of patients to access care at the right time in the right place. High bed occupancy resulted in reduced flow from emergency departments into the acute bed base, and in turn impacted on waiting times in A&E, ambulance handover delays and failure to meet ambulance response time standards. This was mitigated through the System Coordination Centre, NHS Cheshire and Merseyside's Urgent and Emergency Care recovery programme and national support programmes.
- in January 2025, four of our hospital providers declared critical incidents: Mersey and West Lancashire, Wirral University and Liverpool University Hospital Trusts declared incidents due to urgent and emergency care pressures, and Countess of Chester Trust reported a critical incident due to a business continuity incident which significantly impacted their emergency department for a short time, but required wider system support.
- East Cheshire NHS Trust has continued to be an outlier for hospital mortality. A comprehensive programme of support was established, overseen by a Quality Improvement Group. Board to Board meetings were held and reports on progress have been made to each meeting of the NHS Cheshire and Merseyside Board, with improvments being seen throughout the year.

2.2.3.29 Review of economy, efficiency and effectiveness of the use of resources

NHS Cheshire and Merseyside's constitution requires it to ensure that it receives value for money. To ensure that resources are used economically, efficiently and with effectiveness:

- the Board provides active leadership of the organisation within a framework of prudent and effective controls that enable risk to be assessed and managed.
- the Audit Committee, as a committee of the Board, is pivotal in advising the Board on the effectiveness of the system of internal control. Any significant issues would be reported to the Board via the Audit Committee.
- NHS Cheshire and Merseyside's committees' responsibilities include overseeing the development and review of: strategy and commissioning plans, annual commissioning intentions, financial plans (including delivery), undertaking detailed scrutiny of performance, contract monitoring and financial management on behalf of NHS Cheshire and Merseyside, and also reviewing and monitoring the organisational improvement plan. NHS Cheshire and Merseyside's committees formally report to the Board, escalating issues as required.
- Directors' roles and responsibilities are aligned to ensure systems of internal control are in place and implemented effectively throughout the organisation.
- the constitution includes a Scheme of Reservation and Delegation which sets out the procurement processes and financial limits that are delegated to management.
- a procurement strategy and procurement processes have been developed that include securing quality services and value for money as key criteria, whilst also ensuring compliance with the new Procurement Act 2023, which came into force on February 24, 2025.
- as explained throughout this report, extensive partnership working with local authorities and with service providers is undertaken through our place structure which helps ensure that local services are designed and delivered with economy, efficiency and effectiveness as a key priority.

- processes are monitored through risk assessment and through regular reports on procurement, including any tender waivers together with the reasons for those waivers.
- Internal Audit provides reports to each meeting of the Audit Committee and full reports to the Executive Director of Finance. The Audit Committee also receives details of any actions that remain outstanding from the follow up of previous audit work. The Executive Director of Finance and Associate Director of Governance and Corporate Affairs also meets regularly with the Audit Manager.
- External Audit provides external audit annual management letter and progress reports to the Audit Committee.

External auditors are required to be satisfied whether the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. In June 2024, our external auditors provided a report on the arrangements to deliver value for money in the year to 31 March 2024 covering arrangements for financial sustainability, governance, and improving economy, efficiency, and effectiveness. In the June 2024 report on 2023-24, our external auditors identified no significant weaknesses in arrangements identified for governance, and improving economy, efficiency, and effectiveness, noting that improvement arrangements that had been recommended in the 2022-23 report had been addressed.

A further report was issued in June 2025 relating to arrangements for the financial year 2024-25. No significant weaknesses were identified in arrangements for governance, and improving economy, efficiency, and effectiveness. On financial sustainability, our external auditors made two improvement recommendations whilst also assessing this area as no risk of significant weaknesses. The recommendations were that the ICB should continue working with system partners to develop the Cheshire and Merseyside system medium term financial plan. The ICB should also work with system partners to develop robust recurrent savings schemes to support the delivery of the 2025/26 financial plan.

The NHS Oversight assurance framework is aligned to the ambitions set out in the NHS Long Term Plan and in operational planning and contracting guidance issued for 2024-2025. Metrics in relation to Finance and Use of resources include ensuring NHS Cheshire and Merseyside meets its financial duties and an assessment of capabilities on Strategy and Planning; Commissioning; Assuring performance, Quality and Delivery; and Effective Governance and People. These are also areas of focus for the Board.

Integrated Care Systems are required to demonstrate how, as organisations, we unite to reduce inequalities. NHS Cheshire and Merseyside is committed to use the scale and funding of partners to improve how our local economies flourish. Sustainability leaders throughout Cheshire and Merseyside are working with social value experts to do just this. In 2024, we embarked on a transformational approach to maximise every penny of social value. All procurement includes a 10% social value requirement, based on a set of co-produced target operating models aligned with our Marmot principles.

Our procurement processes facilitates connections between prospective bidders and our voluntary sector as the recipient of this added value to ensure this goes directly into our communities.

2.2.3.30 Commissioning of delegated specialised services

NHS Cheshire and Merseyside signed a delegation agreement with NHS England and held full commissioning responsibilities for delegated services during the 2024-2025 reporting period.

Between the internal arrangements implemented by the ICB and that of the North West Specialised Services Joint Committee, it is to the best of the knowledge of NHS Cheshire and Merseyside that the commissioning of all delegated services has been compliant with the 10 core commissioning requirements – as set out in the 2024-2025 Delegated Commissioning Assurance Guidance, published by NHS England – including the requirement that all conditions set out in the delegation agreement are being met.

Where there were known compliance issues, the NHS Cheshire and Merseyside leadership has engaged with NHS England's regional leadership to notify and address such issues in a timely manner.

The NHS Cheshire and Merseyside leadership is able to provide the necessary evidence of core commissioning requirements compliance, should NHS England or a third party ask for such evidence.

2.2.3.31 Delegation of Integrated Care Board functions

NHS Cheshire and Merseyside has delegated responsibility for some of its functions to its committees and Joint Committees and this is set out in the Committees terms of reference and the ICB scheme of reservation and delegation. The Board remains accountable for these functions and has put in place reporting and assurance arrangements requiring all committees to:

- submit regular reports of their business to the Board of NHS Cheshire and Merseyside
- make minutes of their meetings available to the Board of NHS Cheshire and Merseyside
- prepare an annual report outlining how it has delivered its responsibilities and submit this to the Board of NHS Cheshire and Merseyside.

NHS Cheshire and Merseyside has also entered into individual Section 75 arrangements with each of the nine local authorities across Cheshire and Merseyside. Through these individual arrangements NHS Cheshire and Merseyside has delegated decision making authority to each place through the formation of Section 75 Joint Committees with the local authorities, and authority given to NHS Cheshire and Merseyside representatives on budgets and functions that fall under the individual Section 75 Agreement, for example in relation to the Better Care Fund.

NHS Cheshire and Merseyside has also discharged significant decision-making authority to several key posts within the organisation which enables these individuals to have the authority to make decisions on behalf of NHS Cheshire and Merseyside on functions and budgets within a number of forums across all nine places in Cheshire and Merseyside.

This authority is outlined within the NHS Cheshire and Merseyside Scheme of Reservation and Delegation, Operational Scheme of Reservation and Delegation and Standing Financial Instructions.

2.2.3.32 Counter fraud arrangements

Each year, the NHS is vulnerable to over £1 billion worth of fraud, money lost out of the system that would otherwise pay for more doctors, more nurses, and much more else. Fraud has a significant impact on the NHS. It is not a victimless crime.

NHS Cheshire and Merseyside is fully committed to promoting an anti-fraud, bribery and corruption agenda and takes a zero-tolerance approach towards it.

NHS Cheshire and Merseyside contracts Mersey Internal Audit Agency (MIAA) to deliver anti-fraud, bribery and corruption services on its behalf. A nominated Local Counter Fraud Specialist (LCFS) delivers a programme of work in collaboration with key stakeholders to help raise staff and public knowledge and awareness of fraud, bribery and corruption, prevent and detect it, maintain strong governance arrangements around it, and, where appropriate, investigate concerns.

The Executive Director of Finance is the senior responsible officer for fraud, bribery and corruption at NHS Cheshire and Merseyside and, along with the Audit Committee, has responsibility for approving and monitoring the programme of work undertaken. The Associate Director of Finance – Planning and Reporting is the nominated ICB Counter Fraud Champion and provides support to the LCFS. All anti-fraud, bribery and corruption work undertaken by NHS Cheshire and Merseyside is completed in accordance with the Government Functional Standard 013 for Counter Fraud.

In 2024-2025, the LCFS has conducted a number of activities to raise awareness, including circulating articles and newsletters, arranging for the display of anti-fraud posters at Place localities and promoting International Fraud Awareness Week. Additionally, all staff are required to complete a fraud e-learning module, provisioned through ESR, every two years, as part of mandatory training. The LCFS has provided support to the primary care networks through the circulation of alerts to warn of identified fraud threats and delivery of a webinar for GP practice staff, in collaboration with the nominated LCFS' for NHS Greater Manchester and NHS South Lancashire and Cumbria, and the Counter Fraud Manager for NHS England Counter Fraud (North West).

Regarding prevention and detection, a number of activities have been undertaken, including, participation in the National Fraud Initiative data-matching exercise to identify fraud, circulation of local and national alerts in relation to specific identified fraud threats, policy reviews and a national proactive exercise focussed on the areas of due diligence and contract management.

All allegations of fraud, bribery and corruption received by NHS Cheshire and Merseyside are dealt with and, where appropriate, investigated in line with the organisation's Anti-Fraud, Bribery and Corruption Policy and all staff are actively encouraged to report any concerns or suspicions to the LCFS or the national Fraud and Corruption Reporting Line or online reporting form.

2.2.3.33 Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1st April 2024 to 31st March 2025 for NHS Cheshire and Merseyside, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of NHS

Cheshire and Merseyside's system of risk management, governance and internal control.

The Head of Internal Audit concluded that:

*"**Substantial Assurance,** can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently."*

This opinion is provided in the context that NHS Cheshire and Merseyside like other organisations across the NHS is continuing to face a number of challenging issues and wider organisational factors particularly with regards to the recently announced changes to national bodies and the corresponding uncertainty this causes, workforce challenges, financial challenges and increasing collaboration across organisations and systems.

As at month 10 NHS Cheshire and Merseyside was reporting year to date surplus of £22.5m (plan: £51.9m). It was noting continued pressures with Continuing Healthcare (CHC) - £360m spend at month 10 (plan: £336.6m), Mental Health services and prescribing budgets. Whilst slightly behind on efficiencies targets the ICB was expecting to deliver in full the £72.2m efficiency plan by year end. The wider Cheshire and Merseyside ICS system remains challenged financially, as at month 10 reporting a deficit of £109.7m against a planned deficit of £62.4m, however also noting that the trajectory had been improving in recent months.

Performance reporting against key performance indicators shows that NHS Cheshire and Merseyside is delivering above national average in some areas (e.g. cancer survival) but is also continuing to address challenges in a number of key areas with improvement plans implemented and monitored where established.

Scope Limitation: As in 2023/24 we have not completed a review of Continuing Healthcare in year at the request of NHS Cheshire and Merseyside as it continues to resolve known internal process changes.

In providing this opinion we can confirm continued compliance with the definition of internal audit (as set out in your Internal Audit Charter), code of ethics and professional standards. We also confirm organisational independence of the audit activity and that this has been free from interference in respect of scoping, delivery and reporting.

The purpose of our Head of Internal Audit (HoIA) Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of Internal control. As such, it is one component that the Board takes into account in making its Annual Governance Statement (AGS).

The basis for forming our opinion is in Table 19 as follows:

Table 19

Basis for the Opinion
1. An assessment of the design and operation of the underpinning Assurance Framework, risk management systems and supporting processes.
2. An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of systems reviewed and management's progress in respect of addressing control weaknesses identified.
3. An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented.

Commentary

The commentary in Table 20 provides the context for our opinion and together with the opinion should be read in its entirety. Our opinion covers the period 1st April 2024 to 31st March 2025 inclusive and is underpinned by the work conducted through the risk based internal audit plan.

Assurance Framework (AF)

Table 20

Opinion

Structure	The organisation's AF is structured to meet the NHS requirements of assurance best practice model.
Risk Appetite	The organisation considers risk appetite regularly and the risk appetite is used to inform the management of the AF.
Engagement	The AF is visibly used by the organisation.
Quality and Alignment	The AF clearly reflects the risks discussed by the Board.

Core and Risk-Based Reviews Issued

We issued:

5 high assurance opinions:	• Health Inequalities (Population Health Board) • Scheme of Reservation & Delegation • General Ledger • Accounts Receivable • Treasury Management
5 substantial assurance opinions:	• Risk Management Core Controls • CIP Governance • PSIRF • Mandatory Training • Accounts Payable
1 moderate assurance opinion:	• Fit & Proper Person (draft)

0 limited assurance opinions:	N/A
0 no assurance opinions:	N/A
2 reviews without an assurance rating	• SMART Dental • POD Delegations

Data Security and Protection Toolkit (DSPT)

As required by NHS England our work aimed to assess and provide assurance based upon the validity of the organisation's intended final DSPT submission and consider not only if the submission is reasonable based on the evidence submitted, but also provide assurance based on the extent to which information risk has been managed in this context.

Our scope was based on that recommended as part of the Data Security and Protection (DSP) Toolkit Strengthening Assurance Guide published in 2023 by NHS England.

Assessment of Self-Assessment	
In our view, the organisation's self-assessment against the Toolkit deviates only minimally from the Independent Assessment and, as such, the assurance level in respect of the veracity of the self-assessment is:	**Substantial Assurance**
National Data Guardian Standards	
Across the National Data Guardian Standards our assurance rating is based on a mean risk rating score at the National Data Guardian (NDG) standard level. Scores have been calculated using the guidance from the independent assessment Guidance document. As a result of this our overall assurance level across all 10 NDG Standards is rated as:	**Moderate Assurance**

Follow Up

During the course of the year, we have undertaken follow up reviews and can conclude that the organisation has made **good progress** with regards to the implementation of recommendations. We will continue to track and follow up outstanding actions.

Service Auditor Reports

At the time of issuing this opinion the following Service Auditor Report had been provided to the organisation:

- Prior to finalising this opinion we will confirm if further Service Auditor Reports have been issued to the ICB and update our opinion accordingly.

Chris Harrop
Managing Director, MIAA
March 2025

Louise Cobain
Assurance Director, MIAA
March 2025

2.2.3.34 Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within NHS Cheshire and Merseyside who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to NHS Cheshire and Merseyside achieving its principal objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- the Board of NHS Cheshire and Merseyside
- the Audit Committee
- the Quality and Performance Committee
- the NHS Cheshire and Merseyside Executive Team Committee
- Internal audit.

The role and conclusions of each have been considered in the Corporate Governance Report from 2.2.

During the year the Board and Audit Committee have kept under regular review the application of the system of internal control. With the support of Internal Audit where areas for improvement have been identified, prompt appropriate actions have been taken to address any gaps in control and changes made to ensure that the systems in place remain robust and effective.

2.2.3.35 Conclusion

The receipt again of a Substantial Assurance Opinion from our Internal Auditors demonstrates that we have continued to maintain a firm grip on our governance and assurance framework.

We have accepted the recommendations made by our Internal Auditors with regards the areas for improvement as identified as part of the reviews undertaken in 2024-25 and will look to ensure all actions, where possible, will be implemented before Quarter 2 in 2025-2026.

The Annual report identifies significant challenges in relation to delivering within the resources available and increasing productivity in 2025-2026. NHS Cheshire and Merseyside is required to make a number of significant changes to its operating model during 2025-2026 to meet the ministerial requirement that ICBs reduce their running costs by up to 50% and reduce our staffing costs by at least 25%. This cannot and will not detract us from addressing the financial challenges in the system, and continuing our commitment to improving population health and building systems for integration and collaboration. We will be in a strong position to lead the system in the delivery of the requirements of the NHS 10 Year Plan upon its release later in 2025.

2.3 Remuneration and Staff Report

The remuneration and staff report sets out NHS Cheshire and Merseyside's remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers.

2.3.1 Remuneration Report

The Government Financial Reporting Manual requires NHS bodies to prepare a Remuneration Report containing information about directors' remuneration. In the NHS, the report will be in respect of the Senior Managers of the NHS body. 'Senior Managers' are defined as: *'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of NHS Cheshire and Merseyside as a whole, rather than the decisions of individual directorates or departments.'* For the purposes of this report, this includes NHS Cheshire and Merseyside's Board.

This report:

- sets out the process under which the Chair, Executive Directors, Directors and Non-Executive Members were remunerated for the financial year to 31st March 2025
- sets out tables of information showing details of the salary and pension interests of all directors for the financial year to 31st March 2025.

In compliance with Article 21 of the General Data Protection Regulation (GDPR) each member of the Board, detailed in the tables 2.3.1.2 to 2.3.1.6, have given their consent for their information to be included.

2.3.1.1 Remuneration Committee

The Remuneration Committee is established by NHS Cheshire and Merseyside as a Committee of the Board in accordance with its Constitution. The Remuneration Committee is responsible for determining the remuneration and terms and conditions of the Chief Executive, Executive Directors and non-voting directors. The Committee is chaired by a Non-Executive Member and membership comprises all other NHS Cheshire and Merseyside Non-Executive Members.

The Chair undertakes the annual appraisal of the Non-Executive Members and the Chief Executive, who in turn is responsible for assessing the performance of the Executive Directors.

Further details of the activity of the Committee during the year is provided in the Governance Statement at 2.2.2.7, and of its membership is provided at Appendix One.

2.3.1.2 Fair Pay Disclosure - **AUDITED**

Percentage change in remuneration of highest paid director

The percentage change in remuneration of the highest paid director (based on that director's midpoint banding) in comparison to the previous financial year is set out below together with the average percentage change from the previous financial year in respect of employees of the entity, taken as a whole.

Table 21

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	5.0%	N/A
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	5.5%	N/A

Pay ratio information

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director in NHS Cheshire and Merseyside in the year to 31st March 2025 was £272,500 (2023-2024 - £272,500). The relationship to the remuneration of the organisation's workforce is disclosed in Table 22.

Table 22

2024-2025	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	36,483	48.526	62,215
Salary component of total annual remuneration (£)	36,483	48,526	62,215
Pay ratio information	**7.74 : 1**	**5.82 : 1**	**4.54 : 1**
2023-2024			
Total annual remuneration (£)	£34,581	£45,996	£58,972
Salary component of total annual remuneration (£)	£34,581	£45,996	£58,972
Pay ratio information	**7.88 : 1**	**5.92 : 1**	**4.62 : 1**

During the reporting period 2024-2025, no employee received remuneration in excess of the highest-paid director (2023-2024 - no employee). Remuneration ranged from £24,169 to £272,500 (2023-2024 - £21,932 to £272,500).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

As can be seen, pay multiples for the highest paid director against 25th Centile, the median pay centile and 75th centile decreased. The biggest factor was that employees were awarded an average pay rise of 5.5% and the highest paid employee was awarded 5%.

2.3.1.3 Policy on the remuneration of senior managers

In determining and reviewing remuneration for Executive Directors, NHS Cheshire and Merseyside's Remuneration Committee considers relevant benchmarking with other NHS organisations, guidance from NHS England, national inflationary uplifts recommended for other NHS staff and any variation or change to the responsibilities of Directors and the financial circumstances relating to NHS Cheshire and Merseyside.

For the purposes of the Annual Report, Senior Managers are defined as those in Board level positions. Senior managers at NHS Cheshire and Merseyside do not receive performance-related pay or bonuses. All Executive Directors / Other Board Directors have employment contracts which are usually awarded on a permanent basis unless the post is for a fixed period of time. Executive Directors (including the Chief Executive) have a 6-month notice period within their contracts of employment.

2.3.1.4 Remuneration of Very Senior Managers

In respect of those senior managers who are paid more than £150,000 per annum, NHS Cheshire and Merseyside, via its Remuneration Committee takes steps to ensure such remuneration is reasonable and commensurate with the individual's experience, by way of reference to the Very Senior Manager (VSM) Pay Framework and guidance issued to ICBs and considering benchmarking data from other similar organisations.

2.3.1.5 Senior manager remuneration (including salary and pension entitlements) - **AUDITED**

Table 23

1st April 2024 to 31st March 2025							
Name	**Title**	**Salary (bands of £5,000)[1]**	**Expense payments (taxable) to nearest £100****	**Performance pay and bonuses (bands of £5,000)**	**Long term performance pay and bonuses (bands of £5,000)**	**All pension-related benefits (bands of £2,500)[2]**	**TOTAL (bands of £5,000)**
		£000	**£**	**£000**	**£000**	**£000**	**£000**
Raj Jain	Chair	75 - 80	100	-	-	-	75 - 80
Tony Foy	Non-Executive Member	15 - 20	500	-	-	-	15 - 20
Erica Morris	Non-Executive Member	15 - 20	600	-	-	-	15 - 20
Neil Large MBE[6]	Non-Executive Member	15 - 20	800	-	-	-	15 - 20
Hilary Garratt CBE	Non-Executive Member	15 - 20	-	-	-	-	15 - 20
Ruth Hussey CB, OBE, DL	Non-Executive Member	15 - 20	200	-	-	-	15 - 20
Dr Naomi Rankin	Partner Member	10 - 15	-	-	-	-	10 -15
Adam Irvine	Partner Member	10 - 15	-	-	-	-	10 -15
Professor Stephen Broomhead MBE[5]	Partner Member	-	-	-	-	-	-
Cllr Paul Cummins[6]	Partner Member	0 - 5	-	-	-	-	0 – 5
Ann Marr OBE[5]	Partner Member	-	-	-	-	-	-
Joe Rafferty CBE[5,6]	Partner Member	-	-	-	-	-	-
Andrew Lewis[5]	Partner Member	-	-	-	-	-	-
Warren Escadale[5]	Partner Member	-	-	-	-	-	-
Trish Bennett[5]	Partner Member	-	-	-	-	-	-
Graham Urwin[3,4,7]	Chief Executive	270 - 275	100	-	-	60 – 62.5	335 – 340
Claire Wilson[3,4]	Executive Director of Finance	130 - 135	-	-	-	35 -37.5	165 - 170
Mark Bakewell[3,4]	Interim Executive Director of Finance	55 - 60	300	-	-	17.5 - 20	70 - 75
Professor Rowan Pritchard-Jones[3]	Medical Director	185 - 190	200	-	-	25 -27.5	210 - 215
Christine Douglas MBE[3,4]	Executive Director of Nursing & Care	175 - 180	700	-	-	-	175 - 180

******Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

1. Where an executive member sacrifices salary which is used to lease a motor vehicle, the salary sacrificed is included within salary because the ICB considers this as salary earned that has been used by the employee to lease motor vehicles.
2. The value of pension benefits accrued during the period is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. The value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

1st April 2024 to 31st March 2025
3. The Chief Executive, Executive Director of Finance (including interim), Executive Director of Nursing and Care and Executive Medical Director are engaged under contracts of services and are employees. 4. Claire Wilson left the ICB on 8 December 2024. Mark Bakewell took up the role as Interim Executive Director of Finance on 9 December 2024. Graham Urwin retired on 18 October 2024 and returned on 4 November 2024. Christine Douglas MBE retired on 31 October 2024 and returned on 18 November 2024. 5. Ann Marr OBE, Joe Rafferty CBE, Professor Steven Broomhead MBE, Andrew Lewis, Warren Escadale and Trish Bennett are Partner Board Members and are not remunerated by the ICB for their work as partner members. Ann Marr's employer charges the ICB for other services as executive lead for Cheshire and Merseyside Acute Specialist Trust Alliance and in the year these charges fell in the range £30k -£35k. 6. Cllr Paul Cummins left on 31 May 2024, Professor Joe Raffety left on 30 September 2024 and Neil Large left on 28 February 2025. 7. As explained in the pensions table in section 2.3.1.6 below, Graham Urwin retired and returned in the year. He contributes to the 2015 section of the NHS Pension Scheme, having retired from the other parts of the scheme, and therefore the pension benefit is based on that section of the scheme only.

Table 24

1st April 2023 to 31st March 2024							
Name	**Title**	**Salary (bands of £5,000)**	**Expense payments (taxable) to nearest £100****	**Performance pay and bonuses (bands of £5,000)**	**Long term performance pay and bonuses (bands of £5,000)**	**All pension-related benefits (bands of £2,500)**	**TOTAL (bands of £5,000)**
		£000	**£**	**£000**	**£000**	**£000**	**£000**
Raj Jain	Chair	75 - 80	-	-	-	-	75 - 80
Tony Foy	Non-Executive Member	20 - 25	-	-	-	-	20 - 25
Erica Morris	Non-Executive Member	15 - 20	200	-	-	-	15 - 20
Neil Large MBE	Non-Executive Member	15 - 20	200	-	-	-	15 - 20
Hilary Garratt CBE	Non-Executive Member	10 -15	100	-	-	-	10 - 15
Ruth Hussey CB, OBE, DL	Non-Executive Member	5 - 10	-	-	-	-	5 - 10
Dr Naomi Rankin	Partner Member	10 - 15	-	-	-	-	10 - 15
Adam Irvine	Partner Member	20 - 25	-	-	-	-	20 - 25
Professor Stephen Broomhead MBE[4]	Partner Member	-	-	-	-	-	-
Cllr Paul Cummins	Partner Member	10 - 15	-	-	-	-	10 - 15
Ann Marr OBE[4]	Partner Member	-	-	-	-	-	-
Joe Rafferty CBE[4]	Partner Member	-	-	-	-	-	-
Graham Urwin[3]	Chief Executive	270 - 275	100	-	-	57.5 - 60	330 - 335
Claire Wilson[3]	Executive Director of Finance	180 - 185	-	-	-	25 - 27.5	205 - 210
Professor Rowan Pritchard-Jones[3]	Medical Director	175 - 180	-	-	-	50 - 52.5	225 - 230
Christine Douglas MBE[3]	Executive Director of Nursing & Care	175 - 180	300	-	-	-	175 - 180

******Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

1. Where an executive member sacrifices salary which is used to lease a motor vehicle, the salary sacrificed is included within salary because the ICB considers this as salary earned that has been used by the employee to lease motor vehicles.
2. The value of pension benefits accrued during the period is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. The value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an

estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

3. The Chief Executive, Executive Director of Finance, Executive Director of Nursing and Care and Executive Medical Director are engaged under contracts of services and are employees.
4. Ann Marr OBE, Professor Joe Rafferty CBE and Professor Steven Broomhead MBE are Partner Board Members and are not remunerated by the ICB.

2.3.1.6 Pension benefits as at 31st March 2025 - **AUDITED**

All salaried Board members, except for our Non-Executive Members, had access to the NHS Pension Scheme. Details of each pension scheme can be found online.[19] (see note 4.5 of the Annual Accounts for further information).

Table 25

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age 31 March 2025 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 31 March 2024	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2025	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Graham Urwin – Chief Executive	2.5 - 5	-	5 - 10	-	1,993	46	161	0
Mark Bakewell - Interim Executive Director of Finance	0 – 2.5	0 – 2.5	40 - 45	105 - 110	757	16	878	0
Professor Rowan Pritchard-Jones – Medical Director	2.5 – 5	-	65 - 70	160 - 165	1,259	27	1,394	0
Claire Wilson – Director of Finance to 8 Dec 2024	2.5 - 5	-	60 - 65	145 - 150	1,112	30	1,248	0

a) The pension entitlement above is the total pension entitlement for Board member and is not reduced for the effect contributions made in employment for other entities.
b) A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.
A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.
The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
c) Real Increase in Cash Equivalent Transfer Value is the increase in CETV that is funded by the Employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).
d) Christine Douglas is retired from the NHS Pension Scheme.
e) The 1995 and 2008 sections of the NHS Pension Scheme closed on 31 March 2022 and all staff that were contributing to those schemes on that date were automatically moved to the 2015 scheme on 1 April 2022. Benefits in the 1995 and 2008 sections of the scheme were deferred and from 1 March 2022 contributions are made to the 2015 scheme. Graham Urwin took partial retirement on 18 October 2024, drawing benefits from the 1995 and 2008 section of the scheme, and returned to work on 4 November 2024 continuing to pay contributions into the 2015 section of the scheme. Accordingly, the calculations for Graham Urwin are based on the values attributable to the 2015 section of the scheme only. The CETV for Graham Urwin reported at 31 March 2024 includes values relating to the 1995, 2008 and 2015 sections. The CETV reported at 31 March 2025 includes only those values relating to the 2015 section of the scheme.

[19] https://www.nhsbsa.nhs.uk/member-hub (last checked on 02.06.24)

Pension benefits as at 31st March 2024 were:

Table 26

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age 31 March 2024 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 31 March 2023	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2024	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Graham Urwin – Chief Executive	2.5 – 5	-	75 - 80	220 - 225	1,713	73	1,993	-
Professor Rowan Pritchard-Jones – Medical Director	0 - 2.5	40 - 42.5	55 - 60	155 - 160	872	275	1,259	-
Claire Wilson – Executive Director of Finance	0 - 2.5	17.5 - 20	50 - 55	135 - 140	801	206	1,112	-

a) The pension entitlement above is the total pension entitlement for Board member and is not reduced for the effect contributions made in employment for other entities.
b) A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.
A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.
The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
c) Real Increase in Cash Equivalent Transfer Value is the increase in CETV that is funded by the Employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).
d) Graham Urwin rejoined the pension scheme in the year. Christine Douglas opted out from the NHS Pension Scheme and carried on working in a non-pensionable capacity.

2.3.1.7 Compensation on early retirement or for loss of office

There were no payments for compensation on early retirement or for loss of office in 2024-2025 (2023-2024 – none).

2.3.1.8 Payments to past directors

No payments have been made to past senior managers in 2024-2025 (2023-2024 – none).

2.3.1.9 Exit Packages

There were no exit packages for members of the Board. Exit packages for other staff are set out in the staff report.

2.3.2 Staff Report

As at 31st March 2025, NHS Cheshire and Merseyside employed 1,167 staff. The headcount has increased by 86 compared to last year's headcount which was reported as 1,081 on 31st March 2024. There have been several TUPE transfers of staff into NHS Cheshire and Merseyside over that last 12 months, 87 All Age Continuing Care staff were transferred in from NHS Midlands and Lancashire CSU and Mersey Care NHS Foundation Trust on 1st April 2024 and 82 medicines management staff were transferred in from Mersey Care NHS Foundation Trust, NHS Midlands and Lancashire Commissioning Support Unit and from the Countess of Chester Hospital NHS Foundation Trust.

2.3.2.1 Number of senior managers and gender split

At 31st March 2025, the headcount, including the Board members, at NHS Cheshire and Merseyside consisted of the following breakdown:

Table 27

	Headcount by Gender		
Staff Grouping	**Female**	**Male**	**Totals**
Board (including office holders)	7	9	**16**
Other Senior Management (Band 8C+)	124	67	**191**
All Other Employees	786	174	**960**
Grand Total	**917**	**250**	**1,167**

The percentage split by gender was as follows:

Table 28

	% by Gender	
Staff Grouping	**Female**	**Male**
Board (including office holders)	43.8%	56.2%
Other Senior Management (Band 8C+)	64.9%	35.1%
All Other Employees	81.9%	18.1%
Grand Total	**78.6%**	**21.4%**

2.3.2.2 Staff numbers and costs - **AUDITED**

Average staffing numbers, on a full-time equivalent basis, by occupation during the year are summarised in the Table 29:

Table 29

Staff Grouping	**Permanent**	**Other**	**Total**
Administrative and Estates	669	41	710
Medical and Dental	14	1	15
Nursing and Midwifery	185	15	200
Scientific/ Therapeutic / Technical	185	3	188
Total	**1,053**	**60**	**1,113**

Total staffing costs are set out in note 4 to the accounts and are summarised in Table 30.

Table 30

	Permanent Employees £000s	Other £000s	Total £000s
Salaries and wages	56,740	1,362	58,102
Social security costs	6,455	-	6,455
Employer contributions to the NHS Pension Scheme	12,803	-	12,803
Other pension costs	18	-	18
Apprenticeship Levy	300	-	300
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	80	-	80
Gross Employee Benefits Expenditure	**76,396**	**1,362**	**77,757**

A breakdown of staff Headcount, excluding Non-Executive members, by band at 31st March 2025 is outlined in Table 31.

Table 31

Pay Band	Headcount
Band 2	4
Band 3	55
Band 4	85
Band 5	138
Band 6	183
Band 7	222
Band 8A	164
Band 8B	109
Band 8C	83
Band 8D	16
Band 9	42
Medical	29
VSM	32
Total	**1,162**

2.3.2.3 Sickness absence data

The sickness absence data for NHS Cheshire and Merseyside in the calendar year 2024 was whole time equivalent (WTE) days available of 237,268.9 and WTE days lost to sickness absence of 10,723 and average working days lost per employee was 10.17 which was managed through the absence management policy (Table 32).

Table 32

Staff sickness absence 2024	Number
Total days lost	10,723
Total staff years	1,055
Average working days lost	10.17

2.3.2.4 Staff turnover percentages

NHS Cheshire and Merseyside's Staff Turnover Rate for 2024-2025 has been calculated by dividing the total Full Time Equivalent (FTE) Leavers in-year by the average FTE Staff in Post during the year. The Total FTE Leavers in year was 96.15. The Average FTE Staff in Post during the year was 1,070.91 (2023-2024 – 971.41). The Staff Turnover Rate for the year was 8.98% (2023-2024 – 13.07%) (Table 33).

Table 33

Staff turnover	Number
Average FTE employed	1,070.91
Total FTE leavers	96.15
Turnover rate	8.98

Throughout the period NHS Cheshire and Merseyside's staff turnover rate was reported regularly to its Board and Executive Team. Workforce data provided to NHS Cheshire and Merseyside by Midlands and Lancashire Commissioning Support Unit outlined all recorded reasons for staff leaving NHS Cheshire and Merseyside with the top reasons being:

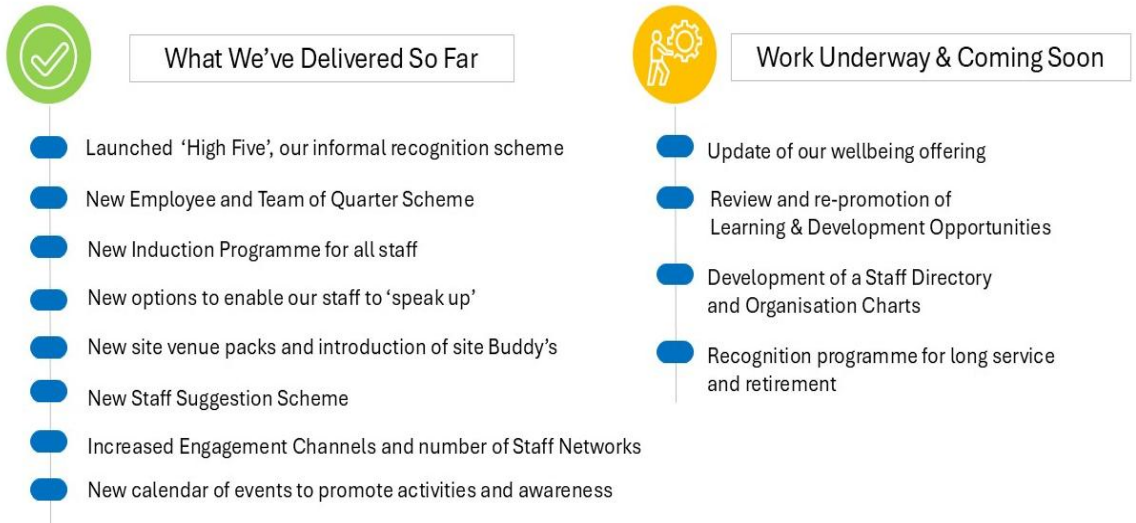
- Voluntary Resignation – Promotion
- Retirement.

2.3.2.5 Staff Survey

Following on from the publication of the results for 2022 - 2023, extensive staff engagement was undertaken to develop team specific actions plans, as well as an organisational action plan.

As part of that engagement, 18 individual Executive meetings were held with the Staff Engagement Forum and People Operation Group representatives. Results were presented to over 330 staff at We Are One and there were facilitated People Promise sessions where over 600 staff attended to give feedback. The feedback following all of these engagement sessions was collated and presented as 'you said/we did', detailed in Figure 32.

Figure 32: People Promise – You Said, We Did



Through the months of September and November 2024, NHS Cheshire and Merseyside participated in their second annual staff survey. Response rates decreased from the previous year from 77% to 73%, although the headcount was higher this year so there were more staff surveyed.

The results from the 2024 survey, against the seven areas of the NHS People Promise, are detailed in Table 34, with comparisons from the previous year.

Table 34

People Promise Area		Score (out of 10)	
		2024	2023
1	We are compassionate and inclusive	7.47	7.48
2	We work flexibly	7.45	7.28
3	We are a team	7.25	7.19
4	We have a voice that counts	6.79	6.81
5	We are recognised and rewarded	6.65	6.67
6	We are safe and healthy	6.40	6.35
7	We are always learning	5.13	5.23

In addition to the People Promise Themes, the survey also produces reports related to staff morale and engagement.

Staff morale is measured across three sub themes in relation to staff thinking about leaving, work pressures and stressors. The score in this area of the survey was 5.73 compared to 5.74 from the previous year.

Staff engagement is measured across three sub themes relating to staff motivation, their involvement in work and advocacy in relation to recommending the organisation as a place to work and the NHS as place to treated. The score in this area of the survey was 6.50 compared with 6.65 from the previous year.

Some of the key areas of focus for the coming year relate to staff wellbeing as far as feedback from staff around time and work pressures, a review of the appraisal system and process and the learning and development offer.

A detailed presentation of the survey results was delivered to the Executive Team in March and following the lifting of the NHS England embargo on sharing information in mid-March, presentations are planned for ‘We Are One’, Staff Engagement Forum, People Operations Group.

Upon completion of the communication cascade, an Assurance Report detailing actions and plans for the coming year will be delivered to the NHS Cheshire and Merseyside People Committee.

Staff engagement sessions will be planned throughout April and May 2025, both face to face and online, to provide staff with the opportunity to provide feedback and make recommendations for further improvement.

2.3.2.6 Staff policies

NHS Cheshire and Merseyside is committed to creating an environment in which people can feel valued, where people are treated fairly and with dignity and respect.

Our people policies are reviewed regularly via the HR Policy Review Group in partnership with staff side colleagues. This process ensures all staff policies remain up to date.

NHS Cheshire and Merseyside conducts an Equality Impact Analysis for all strategies, policies and processes to ensure it treats people fairly and does not undermine their rights.

Policy reviews are reflective of legislative changes and any changes to NHS employment terms within the Agenda for Change framework. NHS Cheshire and Merseyside is aligned to the ongoing development of a suite of people policy frameworks being undertaken by NHS England. This will introduce a new format for policies ensuring they are simple and easy to read, staff-centric, inclusive and accessible and reflective of best practice.

The adoption of the national people policy frameworks into NHS Cheshire and Merseyside will mean staff are supported by managers and colleagues and will help build a culture of compassion and inclusion across the service and:

- improve inclusion and diversity.
- ensure consistency across the system and NHS, improving staff experience and saving time.
- reduce absence, staff turnover, grievances and disputes, improving our staff survey results.
- reduce duplication of effort across our organisation, enabling the scaling of people services and cross-system working.
- ensure our organisation continues to align to the NHS Long term Workforce Plan and People Promise.

NHS Cheshire and Merseyside is committed to creating an environment that promotes equality and embraces diversity in its performance as an employer. It adheres to legal and performance requirements and mainstreams its equality and diversity principles through its policies, procedures and processes. Policies are equality impact assessed during the policy development processes to ensure that our policies do not have an adverse impact in response to the requirements of The Equality Act 2010. NHS Cheshire and Merseyside will act when necessary to address any unexpected or unwarranted disparities and monitor workforce and employment practices to ensure that employment policies are fairly implemented.

The Recruitment and Selection Policy aims to ensure compliance with current legislation for employing staff in accordance with the Equality Act, Immigration Rules and the Disclosure and Barring Service (as applicable). It operates a fair and objective system for recruiting, which places emphasis on individual skills, abilities and experience. Selection criteria contained within our Job Descriptions and Person Specifications are reviewed to ensure that they are justifiable and so do not unfairly discriminate directly or indirectly and are essential for the effective performance of the role.

NHS Cheshire and Merseyside is positive about employing people with disabilities and all applicants who declare that they have a disability and who meet the essential criteria for a post are shortlisted and invited to interview. We are committed to making reasonable adjustments in the workplace, including appropriate training, to

support the continuation of employment. Recruitment and selection training is available for managers and regular support, advice and guidance is provided to recruiting managers by the Recruitment Team.

We strive to enable all staff to achieve their full potential in an environment of dignity and mutual respect. Support for staff who become disabled is provided under the Management of Attendance Policy and Performance Management Policy. Where medical advice recommends temporary or permanent changes, managers will consider how we can support our employees to continue in their present role or where more appropriate to an alternative role. Redeployment may be on a temporary or permanent basis depending on the needs of the individual and the requirements of the role.

2.3.2.7 Equality, Diversity and Human Rights

Gender Pay Gap (GPG) is a statutory requirement for all NHS organisations who have 250 or more staff. The Gender Pay Gap results are an important driver of our equality and inclusion activity in relation to improving gender equality.

As of February 2025, the NHS Cheshire and Merseyside pay profile for gender across senior pay bands (Table 36 - Quartile 4) is detailed below. The significantly higher percentage of males in this quartile compared with those in other quartiles contributes significantly to the current pay gap difference of 21.13%. This figure represents a significant increase in the pay gap figure reported for 2024 which was 18.72% (See EDI Annual Report[20]).

Table 35

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	33.1177	26.0571
Female	26.1216	23.5226
Difference	6.9961	2.5345
Pay Gap %	21.13%	9.73%

Table 36

Quartile	Female	Male	Female %	Male %
1	220.00	44.00	83.33	16.67
2	215.00	50.00	81.13	18.87
3	175.00	62.00	73.84	26.16
4	206.00	86.00	70.55	29.45

Workforce Race Equality Standard (WRES) - NHS Cheshire and Merseyside submitted its WRES data return in August 2024 and published its report and action plan, as required. The nine WRES indicators cover recruitment and pay; access to training; disciplinary; discrimination, bullying and harassment and NHS Cheshire and Merseyside Board membership. The current NHS Cheshire and Merseyside ethnicity profile can be viewed in the Annual WRES Report.[21]

The main purpose of the WRES as outlined by NHS England is to:

- help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against nine indicators
- produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and,
- improve BME representation at the Board level of the organisation.

[20] https://www.cheshireandmerseyside.nhs.uk/media/v4aainar/equality-diversity-and-inclusion-annual-report-2023_2024.pdf (last checked 02.06.25)
[21] https://www.cheshireandmerseyside.nhs.uk/media/5efpagko/workforce-race-equality-standard-report-2023_2024.pdf (last checked 02.06.25)

The Workforce Disability Equality Standard (WDES) is a data-based standard that uses a series of measures to improve the experiences of disabled staff in the NHS. The WDES was mandated by the NHS Standard Contract and became applicable to all NHS trusts and foundation trusts in April 2019.

Mandatory reporting on WDES is restricted to NHS trusts and foundation trusts. However, in accordance with its commitment to best practice beyond compliance, NHS Cheshire and Merseyside reviewed its workforce disability data for the first time in 2023. More detailed information relating to NHS Cheshire and Merseyside can be viewed in the Annual WDES Report.[22]

NHS Cheshire and Merseyside has embarked on a journey to develop an inclusive culture. The NHS Cheshire and Merseyside Culture Framework was built in 2023-2024 on the NHS Constitution, Nolan Principles and Equality Act. It was developed in partnership with staff, tested with leadership and aligned to the direction of our integrated care system. It enabled us to develop new ways of working towards improving health outcomes, tackling health inequalities, delivering best value and supporting social and economic growth.

Over the last year, the NHS Cheshire and Merseyside culture framework has taken a front seat in terms of visible optics on the staff hub, featured at the forefront of recruitment and induction for new starters and remained central to commissioning for integrated services. The process of embedding the culture framework has and continues to be anchored to a five-step approach for cultural stability to include 1) awareness raising, 2) skills development, 3) leadership and management practice, 4) process and policy redesign and 5) governance, assurance and accountability alignment.

The culture framework now sits at the heart of the NHS Cheshire and Merseyside brand, ways of working, systems and processes and how staff go about our work, day to day. It is embedded into the cyclical appraisal processes and all people management practices to create cohesive alignment between the employer – employee psychological contract.

In December 2024, the NHS Cheshire and Merseyside achieved accreditation of the Navajo Standard. The standard identifies on going actions that NHS Cheshire and Merseyside must maintain to ensure the needs of our LGBTQ+ staff and patients are fully understood and improved upon.

During 2024, the three equality networks for BAME, Disability and LGBTQI+ have continued to identify actions to cultivate an inclusive culture. This includes understanding from the networks what is needed to support inclusive recruitment, policy impacts, effective staff engagement and staff wellbeing. To this end work towards achievement of the NWBAME Assembly Anti-Racism Framework and Disability Confidence continues.

2.3.2.8 Trade Union Facility Time Reporting Requirements

The Trade Union (Facility Time Publication Requirements) Regulations 2017 which took effect from 1 April 2017, require all public-sector organisations that employ more

[22] https://www.cheshireandmerseyside.nhs.uk/media/e5fe1xmp/workforce-disability-equality-standard-report-2023_2024.pdf (last checked 02.06.25)

than 49 full-time employees, and have at least one trade union representative, to submit data relating to the use of facility time in their organisation.

Facility time is paid time-off during working hours for trade union representatives to carry out trade union duties. The reporting period is 1st April to 31st March with submissions due by 31st July.

Reporting covering the period 1st April 2024 to 31st March 2025 will be published on the NHS Cheshire and Merseyside website by 31st July 2025 as per statutory regulations.

2.3.2.9 Consulting with staff

NHS Cheshire and Merseyside utilises the Staff Partnership Forum facilitated by Midlands and Lancashire Commissioning Support Unit to discuss a range of issues affecting staff. It is recognised that NHS Cheshire and Merseyside has undergone a significant period of organisational change and has sought to engage with staff in local meetings and hold additional extra meetings to consult, discuss, debate and inform staff where changes are planned that impact on them directly.

NHS Cheshire and Merseyside is committed to staff engagement and 'Listening Well' and we have adapted NHS England's Listening Well Guidance. We have many mechanisms as part of our staff engagement strategies including NHS Staff Survey, Pulse Survey and local listening including Freedom to Speak Up Guardians and Ambassadors, mapping of teams' local staff briefings and away days, new starter questionnaires, exit interviews and our monthly We Are One all staff broadcasts.

Two of our other main methods of staff engagement are our Staff Engagement Forum and our Staff Networks.

Our Staff Engagement Forum has been established since May 2023 with the aim to provide two-way communication, an opportunity to engage and involve staff in developments, work programmes and enabling them to contribute to the success of the organisation in delivering our values, vision and strategy objectives. The Forum meets monthly, with representatives from each team.

Topics the forum have been involved in included supporting our NHS Staff Survey action plan, discussing our new staff suggestion scheme, Pulse Survey, Long Service Award, feedback on our internal communications mechanisms and our internal staff insight workforce reports. Impacts of the forum include the development of an NHS Cheshire and Merseyside Volunteering Policy, a task and finish group to look at our activity to promote awareness campaigns and feedback received from the forum has been included in our approach to Long Service Reward.

Recognising the diversity of our staff, we have continued to support several Staff Networks to provide a safe space for our staff, raise awareness of issues within the wider Integrated Care Board and provide a support for staff who may be facing challenges. We had seven staff networks established by April 2024, these were Menopause, working carers, Race Equality Network, LGBTQI+, early careers, disability and neurodiverse and armed forces family support network.

Practical examples supporting us in hearing the voice of our diverse staff and improving staff experience are below:

- Development of a Role Description for Executive Sponsors – so there is a consistent and mutual agreed way that the network works and is supported by their Executive Sponsor.
- Defence Employer Recognition Scheme (ERS) – NHS Cheshire and Merseyside is one of only three Integrated Care Boards in the country to have received the silver accreditation status under the Defence Employer Recognition Scheme. Work is underway to apply for the gold accreditation. The ERS recognises the commitment and support from UK employers for defence personnel. In gaining the silver accreditation NHS Cheshire and Merseyside has demonstrated they have adjusted corporate policies and workplace culture to ensure our Armed Forces community and their families are supported and not disadvantaged. The ICB have now committed to Step into Health to ensure our recruitment processes are fair and armed forces candidates are not disadvantaged.
- Celebrating our diverse staff – we have produced an animation, using our staff network representatives, to highlight the importance of staff reporting their demographics on ESR so we have a better understanding of our workforce. Our networks have also supported all staff events during LGBT History Month to celebrate our workforce and discuss challenges and support available. The Disability and Neurodiverse network held an all staff event with an external speaker discussing the challenges that staff face with ADHD and the support that is available.

2.3.2.10 Expenditure on consultancy

Consultancy is the provision to management of objective advice and assistance relating to strategy, structure, management or operations of an organisation in pursuit of its purposes and objectives. Such assistance will be provided outside the 'business as-usual' environment when in-house skills are not available and will be of no essential consequence and time-limited. Consultancy may include the identification of options with recommendations, or assistance with (but not delivery of) the implementation of solutions.

During 2024-2025, £260k (2023-2024 - £802k) was spent on external consultancy comprising:

- £96k, which was an independent review of collaboration and integration opportunities across heath and social care in Wirral
- £87k on mental health modelling work
- £58k on pre-consultation engagement work on women's hospital services in Liverpool
- £19k advisory work on a VCSE sector collaboration strategy.

2.3.2.11 Off-payroll engagements

Off payroll engagements are payments made by NHS Cheshire and Merseyside to employees outside of its payroll system that are for more than £245 per day and that last for longer than six months.

Table 37: Length of all highly paid off-payroll engagements
For all off-payroll engagements as at 31st March 2025 for more than £245* per day:

	Number
Number of existing engagements as of 31st March 2025	58
for less than 1 year at the time of reporting	17
for between 1 and 2 years at the time of reporting	10
for between 2 and 3 years at the time of reporting	30
for between 3 and 4 years at the time of reporting	1
for 4 or more years at the time of reporting	-

Existing off payroll engagements have been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and where necessary, that assurance has been sought.

Table 38: Off-payroll workers engaged at any point during the financial year
For all off-payroll engagements between 1st April 2024 and 31st March 2025, for more than £245* per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2024 and 31 March 2025	76
No. not subject to off-payroll legislation**	29
No. subject to off-payroll legislation and determined as in-scope of IR35**	47
No. subject to off-payroll legislation and determined as out of scope of IR35**	-
the number of engagements reassessed for compliance or assurance purposes during the year	-
Of which: no. of engagements that saw a change to IR35 status following review	-

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.
**A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 39: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1st April 2024 and 31st March 2025:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period	Nil
Total no. of individuals on-payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on-payroll and off-payroll engagements.	20

2.3.2.12 Exit packages, including special (non-contractual) payments - **AUDITED**

Table 40: Exit Packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	-	-	-	-	-	-	-	-
£10,000 - £25,000	-	-	-	-	-	-	-	-
£25,001 - £50,000	-	-	-	-	-	-	-	-
£50,001 - £100,000	-	-	1	80,000	1	80,000	-	-
£100,001 - £150,000	-	-	-	-	-	-	-	-
£150,001 – £200,000	-	-	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-	-	-
TOTALS	-	-	1	£80,000	1	£80,000		

Redundancy and other departure cost have been paid in accordance with the Agenda for Change Terms and Conditions. Exit costs in this note are accounted for in full in the year of departure. Where NHS Cheshire and Merseyside has agreed early retirements, the additional costs are met by NHS Cheshire and Merseyside and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 41: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	1	80,000
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice*	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval**	-	-
TOTAL	1	£80,000

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match.
No exit packages related to individuals disclosed in the Remuneration Report.

2.4 Parliamentary Accountability and Audit Report

NHS Cheshire and Merseyside is not required to produce a Parliamentary Accountability and Audit Report.

Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at pages 159 to 193.

An audit certificate and report is also included in this Annual Report at pages 152 to 157.

Graham Urwin

Graham Urwin
Chief Executive (01 July 2022 – 31 May 2025)
19 June 2025

Cathy Elliott

Cathy Elliott
Chief Executive (01 June 2025 -)
19 June 2025

Independent auditor's report to the members of the Board of NHS Cheshire and Merseyside Integrated Care Board

Independent auditor's report to the members of the Board of NHS Cheshire and Merseyside Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Cheshire and Merseyside Integrated Care Board (the 'ICB') for the year ended 31 March 2025, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2025 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2024-25 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report and accounts, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report and accounts. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the requirements of the Department of Health and Social Care Group Accounting Manual 2024-25 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2024-25; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the period for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25).
- We enquired of management and the Audit Committee, concerning the ICB's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to management override of controls through inappropriate journal entry.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on large and unusual items and those falling within identified risk criteria including; journals posted by senior management, material journals, year-end journals including accruals, journals posted after 31 March 2025, journals reducing expenditure at the year-end and off ledger adjustments;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of the prescribing accrual;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including the potential for fraud in expenditure recognition. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the ICB operates
  - understanding of the legal and regulatory requirements specific to the ICB including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework**.**

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Annual Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibilities for the review of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the ICB plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the ICB has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Cheshire and Merseyside Integrated Care Board for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2025. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

Use of our report

This report is made solely to the members of the Board of the ICB, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Board of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Board of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

Michael Green

Michael Green, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Manchester
19 June 2025

Annual Accounts

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2025

	Note	2024-25 £'000	2023-24 £'000
Income from sale of goods and services	2	(93,916)	(94,328)
Other operating income	2	(42)	-
Total operating income		**(93,958)**	**(94,328)**
Staff costs	4	77,757	68,662
Purchase of goods and services	5	7,936,698	6,718,986
Depreciation and impairment charges	5	879	1,132
Other operating expenditure	5	8,403	7,757
Total operating expenditure		**8,023,738**	**6,796,536**
Net Operating Expenditure		**7,929,780**	**6,702,208**
Finance expense	8	67	65
Other Gains & Losses	7	296	0
Net expenditure for the Year		**7,930,143**	**6,702,273**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**7,930,143**	**6,702,273**
Other Comprehensive Expenditure			
Total other comprehensive net expenditure		**-**	**-**
Comprehensive Expenditure for the year		**7,930,143**	**6,702,273**

Notes 1 to 24 form part of this statement

Statement of Financial Position as at 31 March 2025

	Note	2024-25 £'000	2023-24 £'000
Non-current assets:			
Property, plant and equipment	9	26	216
Right-of-use assets	9a	3,896	3,067
Total non-current assets		**3,922**	3,282
Current assets:			
Trade and other receivables	11	83,159	95,965
Cash and cash equivalents	12	1	1
Total current assets		**83,160**	**95,966**
Total assets		**87,082**	99,248
Current liabilities			
Trade and other payables	13	(328,261)	(400,842)
Lease liabilities	9a	(632)	(809)
Borrowings	14	(8,321)	(8,129)
Provisions	15	-	-
Total current liabilities		**(337,214)**	(409,780)
Total Assets less Current Liabilities		**(250,132)**	(310,532)
Non-current liabilities			
Lease liabilities	9a	(3,310)	(2,215)
Total non-current liabilities		**(3,310)**	**(2,215)**
Assets less Liabilities		**(253,443)**	(312,747)
Financed by Taxpayers' Equity			
General fund		(253,443)	(312,747)
Total taxpayers' equity		**(253,443)**	(312,747)

Notes 1 to 24 form part of this statement

The financial statements on pages 160 to 193 were approved by the Governing Body on 19 June 2025 and signed on its behalf by:

Cathy Elliott

Cathy Elliott
Chief Executive
Date: 19 June 2025

Statement of Cash Flows for the year ended 31 March 2025

	Note	**2024-25 £'000**	2023-24 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(7,930,143)	(6,702,273)
Depreciation and amortisation	5	879	1,132
Interest paid / received		66	28
Other Gains & Losses	7	296	0
(Increase)/decrease in trade & other receivables	11	12,806	(45,190)
Increase/(decrease) in trade & other payables	13	(72,581)	9,928
Provisions utilised	15	(240)	-
Net Cash Inflow (Outflow) from Operating Activities		**(7,988,916)**	(6,736,375)
Net Cash Inflow (Outflow) from Investing Activities		**-**	(0)
Net Cash Inflow (Outflow) before Financing		**(7,988,916)**	(6,736,375)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		7,989,447	6,732,888
Repayment of lease liabilities		(723)	(860)
Net Cash Inflow (Outflow) from Financing Activities		**7,988,724**	6,732,028
Net Increase (Decrease) in Cash & Cash Equivalents	12	**(193)**	(4,347)
Cash & Cash Equivalents at the Beginning of the Financial Year		**(8,128)**	(3,782)
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**(8,321)**	(8,129)

Notes 1 to 24 form part of this statement

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2025

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2024-25		
Balance at 1 April 2024	**(312,747)**	**(312,747)**
Changes in taxpayers' equity for 2024-25		
Net operating expenditure for the financial year	(7,930,143)	**(7,930,143)**
Net Recognised Expenditure for the Financial year	**(7,930,143)**	**(7,930,143)**
Net funding	7,989,447	**7,989,447**
Balance at 31 March 2025	**(253,443)**	**(253,443)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2023-24		
Balance at 1 April 2023	**(343,361)**	**(343,361)**
Changes in taxpayers' equity for 2023-24		
Net operating costs for the financial year	(6,702,273)	(6,702,273)
Net RecognisedExpenditure for the Financial Year	**(6,702,273)**	**(6,702,273)**
Net funding	6,732,888	6,732,888
Balance at 31 March 2024	**(312,747)**	**(312,747)**

Notes 1 to 24 form part of this statement

Notes to the financial statements

1. **Accounting Policies**

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual (GAM) issued by the Department of Health and Social Care (DHSC). Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2024-25 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.

Public sector bodies are assumed to be a going concern where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 **Joint arrangements**

Joint operations are arrangements in which the ICB has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The ICB includes within its financial statements its share of the assets, liabilities, income and expenses.

1.4 **Pooled Budgets**

The ICB has entered into a pooled budget arrangement with local authorities in Cheshire and Merseyside in accordance with section 75 of the NHS Act 2006. Under the arrangements, funds are pooled for Better Care Funds with local authorities in which a programme is funded to deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. Note 20 provides details of the schemes and the expenditure.

The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

1.4 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the ICB.

1.5 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. Payment terms are standard reflecting cross government principles. Significant terms include all amounts being due within thirty days of the invoice.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Notes to the financial statements

1.6 **Employee Benefits**

1.6.1 **Short-term Employee Benefits**
Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

1.6.2 **Retirement Benefit Costs**
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Some employees are members of National Employment Savings Trust, which is a defined contribution pension scheme. The cost to the ICB of participating in the scheme is the contributions payable to the scheme for the accounting period.

1.7 **Other Expenses**
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.8 **Grants Payable**
Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.9 **Property, Plant & Equipment**

1.9.1 **Recognition**
Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the ICB;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Notes to the financial statements

1.9.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.9.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written out and charged to operating expenses.

1.10 **Intangible Assets**

1.10.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the ICB's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the ICB;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

Notes to the financial statements

1.10.2 **Measurement**

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.10.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.11 **Donated Assets**

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.12 **Government grant funded assets**

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.13 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The ICB assesses whether a contract is or contains a lease, at inception of the contract.

Notes to the financial statements

1.13.1 **The ICB as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.14 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.15 **Provisions**

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 4.03% (2023-24: 4.26%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 4.07% (2023-24: 4.03%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 4.81% (2023-24: 4.72%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 4.55% (2023-24: 4.40%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

Notes to the financial statements

1.16 **Clinical Negligence Costs**
NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB.

1.17 **Non-clinical Risk Pooling**
The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.18 **Contingent liabilities and contingent assets**
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.19 **Financial Assets**
Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:
- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.19.1 **Financial Assets at Amortised cost**
Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Notes to the financial statements

1.19.2 **Financial assets at fair value through other comprehensive income**
A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the ICB elected to measure an equity instrument in this category on initial recognition.

1.19.3 **Financial assets at fair value through profit and loss**
Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

1.19.4 **Impairment of financial assets**
For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets or assets measured at fair value through other comprehensive income, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.20 **Financial Liabilities**
Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.20.1 **Financial Liabilities at Fair Value Through Profit and Loss**
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the ICB's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.20.2 **Other Financial Liabilities**
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.21 **Value Added Tax**
Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 **Foreign Currencies**
The ICB's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the ICB's surplus/deficit in the period in which they arise.

Notes to the financial statements

1.23 **Losses & Special Payments**
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.24 **Critical accounting judgements and key sources of estimation uncertainty**
In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.24.1 **Critical accounting judgements in applying accounting policies**
There are no critical accounting judgements that management has made in the process of applying the ICB's accounting policies that have significant effect on the amounts recognised in the financial statements.

1.24.2 **Sources of estimation uncertainty**
There are no assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

1.25 **New and revised IFRS Standards in issue but not yet effective**

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.
● IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective
for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted
● IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective
for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

2. Other Operating Revenue

	2024-25 Total £'000	2023-24 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**5,556**	10,579
Prescription fees and charges	**39,962**	38,380
Dental fees and charges	**46,662**	44,131
Other Contract income	**1,737**	1,239
Total Income from sale of goods and services	**93,916**	**94,328**
Other operating income		
Non cash apprenticeship training grants revenue	**41**	-
Other non contract revenue	**1**	-
Total Other operating income	**42**	**-**
Total Operating Income	**93,958**	**94,328**

2.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000
Source of Revenue				
NHS	2,671	-	-	210
Non NHS	2,885	39,962	46,662	1,527
Total	**5,556**	**39,962**	**46,662**	**1,737**

	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000
Timing of Revenue				
Point in time	5,556	39,962	46,662	1,737
Over time	-	-	-	-
Total	**5,556**	**39,962**	**46,662**	**1,737**

3. Cost Allocation and Setting of Charges

NHS England, which sets charges on behalf of the ICB, certifies that it has complied with the HM Treasury guidance on cost allocation and the setting of charges. The following table provides details of income generation activities whose full cost exceeded £1 million or was otherwise material:

		Year ended 31 March 2025			Year ended 31 March 2024		
		Income	**Full Cost**	**Surplus/ (Deficit)**	Income	Full Cost	Surplus/ (Deficit)
		£'000	**£'000**	**£'000**	£'000	£'000	£'000
Prescription	Note 2 & 5	39,962	553,936	(513,974)	38,380	531,613	(493,233)
Dental	Note 2 & 5	46,662	194,927	(148,266)	44,131	171,306	(127,175)
		86,624	**748,864**	**(662,240)**	**82,511**	**702,919**	**(620,408)**

The fees and charges information in this note is provided in accordance with section 3.2.12 of the Government Financial Reporting Manual. It is provided for fees and charges purposes and not for International Financial Reporting Standards (IFRS) 8 purposes.

The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay.

Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2024-25, the NHS prescription charge for each medicine or appliance dispensed was £9.90 (2023-24: £9.65). However, around 90% of prescription items are dispensed free each year where patients are exempt from charges. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £32.05 for 3 months (2023-24: £31.25) or £114.50 for a year (2023-24: £111.60) for a year. A HRT prepayment certificate was charged at £19.80 (2023-24: £19.30) for a year. A number of other charges were payable for wigs and fabric supports.

Those who are not eligible for exemption are required to pay NHS dental charges which fall into 3 bands depending on the level and complexity of care provided. The charge for Band 1 treatments was £27.40 (previously £25.80), for Band 2 was £75.30 (previously £70.70) and for Band 3 was £326.70 (previously £306.80).

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total Permanent Employees £'000	Other £'000	2024-25 Total £'000
Employee Benefits			
Salaries and wages	56,740	1,362	**58,102**
Social security costs	6,455	-	**6,455**
Employer Contributions to NHS Pension scheme	12,803	-	**12,803**
Other pension costs	18	-	**18**
Apprenticeship Levy	300	-	**300**
Termination benefits	80	-	**80**
Gross employee benefits expenditure	**76,396**	**1,362**	**77,757**

	Total Permanent Employees £'000	Other £'000	2023-24 Total £'000
Employee Benefits			
Salaries and wages	49,742	2,002	**51,745**
Social security costs	5,694	-	**5,694**
Employer Contributions to NHS Pension scheme	9,547	-	**9,547**
Other pension costs	29	-	**29**
Apprenticeship Levy	222	-	**222**
Termination benefits	1,425	-	**1,425**
Gross employee benefits expenditure	66,659	2,002	**68,662**

4.2 Average number of people employed

	2024-25			2023-24		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**1,053**	**60**	**1,113**	934	58	992

4.3 Exit packages agreed in the financial year

	2024-25 Compulsory redundancies		**2024-25 Other agreed departures**		**2024-25 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	1	80,000	1	80,000
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**1**	**80,000**	**1**	**80,000**

	2023-24 Compulsory redundancies		2023-24 Other agreed departures		2023-24 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	5	34,803	5	34,803
£10,001 to £25,000	-	-	6	117,556	6	117,556
£25,001 to £50,000	-	-	10	338,098	10	338,098
£50,001 to £100,000	-	-	10	614,195	10	614,195
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	2	320,000	-	-	2	320,000
Over £200,001	-	-	-	-	-	-
Total	**2**	**320,000**	**31**	**1,104,652**	**33**	**1,424,652**

There were no departures where special payments were made.

Analysis of Other Agreed Departures

	2024-25 Other agreed departures		2023-24 Other agreed	
	Number	**£**	Number	£
Mutually agreed resignations (MARS) contractual costs	1	80,000	31	1,104,652
Total	**1**	**80,000**	**31**	**1,104,652**

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

4.5.1 Accounting valuation

Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Some employees are members of National Employment Savings Trust, which is a defined contribution pension scheme. The cost to the ICB of participating in the scheme is the contributions payable to the scheme for the accounting period.

5. Operating expenses

	2024-25 Total £'000	2023-24 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	10,325	15,880
Services from foundation trusts	4,220,463	3,316,751
Services from other NHS trusts	1,110,174	952,121
Services from Other WGA bodies	8	2
Purchase of healthcare from non-NHS bodies	936,268	864,561
Purchase of social care	99,955	95,471
General Dental services and personal dental services	194,927	171,306
Prescribing costs	553,936	531,613
Pharmaceutical services	116,221	109,745
General Ophthalmic services	27,003	25,533
GPMS/APMS and PCTMS	604,660	568,211
Supplies and services – clinical	790	2,594
Supplies and services – general	14,661	16,623
Consultancy services	260	802
Establishment	13,274	20,290
Transport	80	33
Premises	22,358	19,303
Audit fees	299	299
Other non statutory audit expenditure		
· Other services	-	103
Other professional fees	9,447	5,992
Legal fees	923	1,559
Education, training and conferences	625	193
Non cash apprenticeship training grants	41	-
Total Purchase of goods and services	**7,936,698**	**6,718,986**
Depreciation and impairment charges		
Depreciation	879	1,120
Amortisation	-	12
Total Depreciation and impairment charges	**879**	**1,132**
Other Operating Expenditure		
Chair and Non Executive Members	207	215
Grants to Other bodies	3,091	2,953
Research and development (excluding staff costs)	4,876	4,599
Expected credit loss on receivables	(63)	(19)
Other expenditure	292	9
Total Other Operating Expenditure	**8,403**	**7,757**
Total operating expenditure	**7,945,981**	**6,727,875**

Audit fees of £299k relate to the ICB only and include Value Added Tax.

In accordance with SI 2008 No. 489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, where an ICB's contract with its auditors provides for a limitation of the auditor's liability, the principal terms of this limitation must be disclosed. The contract for the provision of external audit services is held by Grant Thornton UK LLP. This limitation has been confirmed as £311,400. External audit fees include Value Added Tax (VAT).

Internal audit services during the year were provided by Mersey Internal Audit Agency and hosted by Liverpool University Hospitals NHS Foundation Trust.

6. Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	2024-25 Number	2024-25 £'000	2023-24 Number	2023-24 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	164,300	1,824,577	159,197	1,684,096
Total Non-NHS Trade Invoices paid within target	162,224	1,786,852	157,314	1,642,252
Percentage of Non-NHS Trade invoices paid within target	**98.74%**	**97.93%**	**98.82%**	**97.52%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	15,257	5,423,293	7,615	4,334,594
Total NHS Trade Invoices Paid within target	15,184	5,422,074	7,593	4,333,942
Percentage of NHS Trade Invoices paid within target	**99.52%**	**99.98%**	**99.71%**	**99.98%**

The Better Payment Practice Code requires the ICB to aim to pay all valid invoices by the due date or within 30 days of the receipt of a valid invoice, whichever is later. The Better Payment Practice Code sets out target compliance of 95%.

7. Other gains and losses

	2024-25 £'000	2023-24 £'000
Gain/(loss) on disposal of right-of-use assets other than by sale	296	-
Total	**296**	**0**

8. Finance costs

	2024-25 £'000	2023-24 £'000
Interest		
Interest on lease liabilities	67	28
Other interest expense	1	36
Total finance costs	**67**	**65**

9. Property, plant and equipment

2024-25	Buildings excluding dwellings £'000	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 1 April 2024	685	152	829	(11)	1,656
Disposals other than by sale	-	(152)	-	11	(142)
Cost/Valuation at 31 March 2025	**685**	**-**	**829**	**-**	**1,514**
Depreciation 1 April 2024	537	152	761	(11)	1,440
Disposals other than by sale	-	(152)	-	11	(142)
Charged during the year	137	-	53	-	190
Depreciation at 31 March 2025	**674**	**-**	**814**	**-**	**1,488**
Net Book Value at 31 March 2025	**11**	**-**	**15**	**-**	**26**
Purchased	11	-	15	-	26
Total at 31 March 2025	**11**	**-**	**15**	**-**	**26**
Asset financing:					
Owned	11	-	15	-	26
Total at 31 March 2025	**11**	**-**	**15**	**-**	**26**

9.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	5	5
Information technology	3	5

Furniture and Fittings held by the ICB are fully depreciated and therefore economic lives are deemed to be nil.

2023-24	Buildings excluding dwellings £'000	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 1 April 2023	685	179	2,640	56	3,560
Disposals other than by sale	-	(27)	(1,811)	(67)	(1,905)
Cost/Valuation at 31 March 2024	**685**	**152**	**829**	**(11)**	**1,655**
Depreciation at 1 April 2023	400	179	2,415	56	3,050
Disposals other than by sale	-	(27)	(1,811)	(67)	(1,905)
Charged during the year	137	-	157	-	294
Depreciation at 31 March 2024	**537**	**152**	**761**	**(11)**	**1,439**
Net Book Value at 31 March 2024	**148**	**-**	**68**	**-**	**216**
Purchased	148	-	68	-	216
Total at 31 March 2024	**148**	**-**	**68**	**-**	**216**
Asset financing:					
Owned	148	-	68	-	216
Total at 31 March 2024	**148**	**-**	**68**	**-**	**216**

9a. Leases

9a.1 Right-of-use assets

2024-25	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 01 April 2024	4,601	4,601
Additions	1,783	1,783
ROU Dilapidations	240	240
Lease remeasurement	79	79
Derecognition for early terminations	(1,048)	(1,048)
Cost/Valuation at 31 March 2025	**5,654**	**5,654**
Depreciation 01 April 2024	1,534	1,534
Charged during the year	689	689
Derecognition for early terminations	(465)	(465)
Depreciation at 31 March 2025	**1,758**	**1,758**
Net Book Value at 31 March 2025	**3,896**	**3,896**

NBV by counterparty	**£'000**
Leased from DHSC	1,570
Leased from NHS Providers	592
Leased from external bodies	1,734
Net Book Value at 31 March 2025	**3,896**

9a. Leases cont'd

9a.2 Lease liabilities

2024-25	**2024-25 £'000**	2023-24 £'000
Lease liabilities at 1 April 2024	(3,024)	(2,741)
Additions purchased	(1,783)	(701)
Interest expense relating to lease liabilities	(67)	(28)
Repayment of lease liabilities (including interest)	723	860
Lease remeasurement	(79)	(473)
Disposals on expiry of lease term	-	59
Derecognition for early terminations	287	-
Lease liabilities at 31 March 2025	**(3,942)**	**(3,024)**

9a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2024-25 £'000	Of which: leased from DHSC group bodies **£000**	2023-24 £'000	Of which: leased from DHSC group bodies £'000
Within one year	(751)	(513)	(857)	(509)
Between one and five years	(2,325)	(1,380)	(1,679)	(1,564)
After five years	(1,406)	(417)	(662)	(662)
Balance at 31 March 2025	**(4,482)**	**(2,309)**	**(3,198)**	**(2,735)**

Balance by counterparty		
Leased from DHSC	(1,622)	(1,937)
Leased from NHS Providers	(688)	(798)
Balance as at 31 March 2025	**(2,309)**	**(2,735)**

9a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2024-25	**2024-25 £'000**	2023-24 £'000
Depreciation expense on right-of-use assets	689	825
Interest expense on lease liabilities	67	28
Expense relating to short-term leases	-	28

9a.5 Amounts recognised in Statement of Cash Flows

	2024-25 £'000	2023-24 £'000
Total cash outflow on leases under IFRS 16	723	860

9.a Leases cont'd

Leases are recognised under the leasing standard IFRS 16, applied from 1 April 2022. Under IFRS 16 leases are recognised as a right of use asset with a corresponding lease liability on the Statement of Financial Position. Each lease payment is allocated between a reduction of the liability and the interest expense. The interest expense is charged to the Statement of Comprehensive Net Expenditure over the lease period. The right of use asset is depreciated over the shorter of the asset's useful life and the lease term on a straight line basis. The ICB has applied the exemption for short-term leases (less than 12 months) and low value assets. In these cases, the lease payments associated with them are recognised as an expense in the Statement of Comprehensive Net Expenditure.

As at 31st March 2025 the ICB holds the following leases which fall within the scope of IFRS 16:

Name	Lessor	Use
1829 Building, Chester	NHS Property Services	ICB administrative building
Magdalen House, Bootle	Sefton Council	ICB administrative building
No.1 Lakeside, Warrington	PJD Property Management Ltd	ICB administrative building
Nutgrove Villa, Huyton	NHS Property Services	ICB administrative building
Curzon Road, Southport	NHS Property Services	ICB administrative building
The Ellis Centre, Huyton	NHS Property Services	Community services building
Cunard Building, Liverpool	Liverpool City Council	ICB administrative building
Infinity House, Crewe	Mid Cheshire Hospitals NHS Foundation Trust	ICB administrative building
Old Market House, Wirral	University of Chester	ICB administrative building

The ICB also pays for void space, bookable space and subsidies for properties owned and managed by Community Health Partnerships (CHP) and NHS Property Services (NHSPS), and for space occupied by NHS providers in buildings run by CHP and NHSPS. These do not fall within the definition of a lease and as such are not included in this note.

10. Intangible non-current assets

2024-25	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 1 April 2024	**227**	**227**
Disposals other than by sale	(227)	**(227)**
Cost / Valuation At 31 March 2025	**-**	**-**
Amortisation 1 April 2024	**227**	**227**
Disposals other than by sale	(227)	**(227)**
Amortisation At 31 March 2025	**-**	**-**
Net Book Value at 31 March 2025	**-**	**-**

2023-24	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 1 April 2024	**755**	**755**
Disposals other than by sale	(527)	**(527)**
Cost / Valuation at 31 March 2025	**227**	**227**
Amortisation 1 April 2024	**743**	**743**
Disposals other than by sale	(527)	**(527)**
Charged during the year	12	**12**
Amortisation at 31 March 2025	**227**	**227**
Net Book Value at 31 March 2025	**-**	**-**

10.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	-	-

Intangible assets held by the ICB are fully amortised and therefore economic lives are deemed to be nil.

11.1 Trade and other receivables

	Current 2024-25 £'000	Current 2023-24 £'000
NHS receivables: Revenue	4,572	5,295
NHS prepayments	1,844	-
NHS accrued income	16,443	14,685
NHS Contract Receivable not yet invoiced/non-invoice	98	2,185
Non-NHS and Other WGA receivables: Revenue	30,700	20,461
Non-NHS and Other WGA prepayments	6,686	4,265
Non-NHS and Other WGA accrued income	9,154	39,330
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	3,897	4,682
Expected credit loss allowance-receivables	(81)	(168)
VAT	1,109	686
Other receivables and accruals	8,738	4,543
Total Trade & other receivables	**83,159**	**95,965**
Total current	**83,159**	**95,965**

There were no non-current receivables in 2024-25 (2023-24: Nil)

11.2 Receivables past their due date but not impaired

	2024-25 DHSC Group Bodies	2024-25 Non DHSC Group Bodies	2023-24 DHSC Group Bodies	2023-24 Non DHSC Group Bodies
	£'000	**£'000**	£'000	£'000
By up to three months	45	7,173	2,800	1,808
By three to six months	519	2,944	63	779
By more than six months	1,641	4,840	189	4,024
Total	**2,206**	**14,957**	**3,052**	**6,610**

11.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies	Total
	£'000	**£'000**
Balance at 1 April 2024	**(168)**	**(168)**
Lifetime expected credit losses on trade and other receivables - Stage 2	63	**63**
Amounts written off	23	**23**
Total	**(81)**	**(81)**

12. Cash and cash equivalents

	2024-25 £'000	2023-24 £'000
Balance at 1 April 2024	(8,128)	(3,782)
Net change in year	(193)	(4,347)
Balance at 31 March 2025	**(8,321)**	**(8,129)**
Made up of:		
Cash in hand	1	1
Cash and cash equivalents as in statement of financial position	**1**	**1**
Bank overdraft: Government Banking Service	(8,321)	(8,129)
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**(8,321)**	**(8,129)**
Balance at 31 March 2025	**(8,320)**	**(8,128)**

The bank overdraft shown above is all due within one year and includes BACS payment runs which have been approved in March 2025 but which will be paid from the bank account in April 2025. These outstanding payments give rise to a technical overdraft which is classified as borrowings in accordance with International Financial Reporting Standards. If these payments had not been made the closing cash balance at 31 March 2025 would be £1,405,970 (2023-24: £2,588,403).

13. Trade and other payables

	Current 2024-25 £'000	Current 2023-24 £'000
NHS payables: Revenue	3,701	6,553
NHS accruals	31,579	69,766
Non-NHS and Other WGA payables: Revenue	48,897	51,342
Non-NHS and Other WGA accruals	233,324	257,575
Non-NHS and Other WGA deferred income	509	484
Social security costs	777	781
Tax	826	841
Other payables and accruals	8,649	13,500
Total Trade & Other Payables	**328,261**	**400,842**
Total current	**328,261**	**400,842**

There were no non-current payables in 2024-25 (2023-24: Nil)

Included above are liabilities of £1k due in future years under arrangements to buy out the liability for early retirement over 5 years (2023-24: £1k).

Other payables include £4.937m outstanding pension contributions at 31 March 2025 (2023-24: £4.615m)

14. Borrowings	Current 2024-25 £'000	Current 2023-24 £'000
Bank overdrafts:		
· Government banking service	8,321	8,129
Total Borrowings	**8,321**	**8,129**

The bank overdraft shown above is all due within one year and includes BACS payment runs which have been approved in March 2025 but which will be paid from the bank account in April 2025. These outstanding payments give rise to a technical overdraft which is classified as borrowings in accordance with International Financial Reporting Standards.

14.1 Repayment of principal falling due

	Government banking service 2024-25 £'000	Total 2024-25 £'000	Government banking service 2023-24 £'000	Total 2023-24 £'000
Within one year	8,321	8,321	8,129	8,129
Total	**8,321**	**8,321**	8,129	8,129

15. Provisions

	Current 2024-25 £'000	Current 2023-24 £'000
Other	-	-
Total	**-**	**-**

	Other £'000
Balance at 1 April 2024	-
Arising during the year	240
Utilised during the year	(240)
Balance at 31 March 2025	**-**

Other provisions relate to dilapidation charges associated with The Department, Liverpool, which was disposed of in the current financial year.

16. Contingencies

The ICB does not have any contingencies in 2024-25 (2023-24: Nil)

17. Commitments

The ICB had no capital commitments as at 31 March 2025 (2023-24: nil).

18. Financial instruments

18.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Integrated Care Board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Integrated Care Board's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Integrated Care Board and internal auditors.

18.1.1 Currency risk

The NHS Integrated Care Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS Integrated Care Board has no overseas operations and therefore has low exposure to currency rate fluctuations.

18.1.2 Interest rate risk

The NHS Integrated Care Board has no significant borrowings. The NHS Integrated Care Board therefore has low exposure to interest rate fluctuations.

18.1.3 Credit risk

Because the majority of the NHS Integrated Care Board revenue comes parliamentary funding, it has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

18.1.4 Liquidity risk

NHS Integrated Care Board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Integrated Care Board draws down cash to cover expenditure, as the need arises. The NHS Integrated Care Board is not, therefore, exposed to significant liquidity risks.

18.1.5 Financial Instruments

As the cash requirements of NHS Integrated Care Board are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS Integrated Care Board's expected purchase and usage requirements and NHS Integrated Care Board is therefore exposed to little credit, liquidity or market risk.

18. Financial instruments cont'd

18.2 Financial assets

	Financial Assets measured at amortised cost 2024-25 £'000	**Total 2024-25 £'000**	Financial Assets measured at amortised cost 2023-24 £'000	Total 2023-24 £'000
Trade and other receivables with NHSE bodies	3,546	3,546	4,017	4,017
Trade and other receivables with other DHSC group bodies	18,878	18,878	57,479	57,479
Trade and other receivables with external bodies	51,178	51,178	29,518	29,518
Cash and cash equivalents	1	1	1	1
Total at 31 March 2025	**73,603**	**73,603**	**91,014**	**91,014**
Non-financial instruments				
NHS prepayments	1,844	1,844	-	-
Non-NHS and other WGA Prepayments	6,686	6,686	4,265	4,265
Expected credit loss allowance	(81)	(81)	-	-
VAT	1,109	1,109	686	686
Total current assets as at 31 March 2025 (as per Statement of Financial Position)	**83,160**	**83,160**	**95,965**	**95,965**

18.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2024-25 £'000	**Total 2024-25 £'000**	Financial Liabilities measured at amortised cost 2023-24 £'000	Total 2023-24 £'000
Loans with group bodies	-	**-**	-	-
Loans with external bodies	8,321	**8,321**	8,129	8,129
Trade and other payables with NHSE bodies	581	**581**	1,921	1,921
Trade and other payables with other DHSC group bodies	37,337	**37,337**	75,279	75,279
Trade and other payables with external bodies	292,174	**292,174**	324,560	324,560
Other financial liabilities	-	**-**	-	-
Private Finance Initiative and finance lease obligations	-	**-**	-	-
Total at 31 March 2025	**338,413**	**338,413**	**409,889**	**409,889**
Non-financial instruments				
Non-NHS and Other WGA deferred income	509	**509**	484	484
Social security costs	777	**777**	781	781
Tax	826	**826**	841	841
Total liabilities as at 31 March 2025 (current and non current) as per Statement of Financial Position	**340,524**	**340,524**	**411,995**	**411,995**

19. Operating segments

International Financial Reporting Standards (IFRS) require financial performance to be analysed across key decision making

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning of Healthcare Services	8,024,101	(93,958)	**7,930,143**	87,082	(340,524)	**(253,442)**
Total	**8,024,101**	**(93,958)**	**7,930,143**	**87,082**	**(340,524)**	**(253,442)**

The ICB operates nine segments across nine places all of which commission Health Care Services. As permitted by IFRS 8 information for segments with similar economic characteristics may be presented in aggregate and therefore these segments are included in aggregate above as the commissioning of healthcare services.

20. Joint arrangements - interests in joint operations

20.1 Interests in joint operations

			Amounts recognised in Entities books ONLY							
			2024-25				2023-24			
Name of arrangement	Parties to the arrangement	Description of principal activities	Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Better Care Fund	Cheshire East Council	Pooled budget arrangement for Carers Breaks, Local Authority s256, BCF Home First, Community Equipment and discharge funding	-	-	-	36,127	-	-	-	32,987
Better Care Fund	Cheshire West & Chester Council	Pooled budget arrangement for Carers Breaks, Local Authority s256, BCF Home First, Community Equipment and discharge funding	-	-	-	36,745	-	-	-	32,590
Integrated pooled fund for adult continuing healthcare	St Helens Council	Pooled budget arrangement for the provision of care packages for adults who qualify for CHC/FNC, are S117 or joint funded.	4,291	4,291	-	44,543	2,241	2,241	-	38,728
Better Care Fund	St Helens Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	22,157	-	-	-	20,081
Better Care Fund	Sefton Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	18,861	-	-	-	16,604
Better Care Fund	Wirral Council	Pooled budget arrangement for the commissioning service for the provision of health and social care.	-	-	-	39,272	-	-	-	35,915
Better Care Fund	Halton Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	17,726	-	-	-	16,568
Integrated pooled fund for adult continuing healthcare	Halton Council	Pooled budget arrangement for the provision of care packages for adults who qualify for CHC/FNC, are S117 or joint funded.	3,308	3,308	-	4,239	338	338	-	3,807
Better Care Fund	Warrington Borough Council	Pooled budget arrangement for the integration of Health & Social Care	-	-	-	27,593	-	-	-	25,245
Better Care Fund	Knowsley Metropolitan Borough Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	20,732	-	-	-	19,259
Integrated pooled fund for Mental Health, Community Support Services, Disability Services and Discharge Fund	Knowsley Metropolitan Borough Council	Pooled budget arrangement for the provision of Mental Health Services, Community Support Services, Disability Services and Discharge Fund	747	747	-	28,064	1,293	1,293	-	25,759
Better Care Fund	Liverpool City Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	89,205	-	-	-	81,122
Integrated Community Equipment and Disability Advice Services (ICEDAS)	Liverpool City Council	Pooled budget arrangement for Community equipment	-	-	1,131	1,131	-	-	1,077	1,077
TOTAL			**8,346**	**8,346**	**1,131**	**386,394**	**3,872**	**3,872**	**1,077**	**349,742**

20. Joint arrangements - interests in joint operations cont'd

Cheshire
Cheshire has two pooled budget arrangements with Cheshire East Council and Cheshire West and Chester Council. Under the arrangements, funds are pooled for Cheshire East Better Care Fund and for Cheshire West and Chester Better Care Fund. The pools are hosted by Cheshire East Council and Cheshire West and Chester Council under section 75 agreements between the ICB and the other party. The agreements require that plans are jointly agreed and that services under the agreements are jointly commissioned. Regular meetings are held to monitor plans and commissioning arrangements. This is a joint arrangement and the ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Knowsley
Knowsley has a pooled budget arrangement with Knowsley Metropolitan Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Adult's Learning Disability, Mental Health, Community Support Services and the Better Care Fund. The Better Care Fund is a plan for the ICB and Local Authority to work closely together, driving integration and improved outcomes for the three core initiatives being Localities, Safe Supported Discharge and Access Knowsley. The pool is hosted by KMBC. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Liverpool

Liverpool has a pooled budget arrangement with Liverpool City Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the provision of Integrated Community Equipment and Disability Advice Services (ICEDAS) and to operate a pooled budget for the required Better Care Fund arrangements. The Better Care Fund is hosted by Liverpool City Council. The ICEDAS is hosted by the ICB. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Halton
Halton has a pooled budget arrangement with Halton Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the provision of Adult's Learning Disability, Mental Health, Community Support Services and the Better Care Fund. The pool is hosted by Halton Borough Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

St Helens
St Helens has a pooled budget arrangement with St Helens Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the majority of Continuing Health Care and the Better Care Fund. The pool is hosted by St Helens Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

Sefton
Sefton has a pooled budget arrangement with Sefton Metropolitan Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Self Care, Wellbeing and Prevention, Integrated Care at locality level building on Virtual Ward and Care Closer to Home Initiatives and Intermediate Care and Reablement. The pool is hosted by Sefton Metropolitan Borough Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Warrington
Warrington has a pooled budget arrangement with Halton Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the provision of Adult's Learning Disability, Mental Health, Community Support Services and the Better Care Fund. The pool is hosted by Halton Borough Council The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Wirral
Wirral has a pooled budget arrangement with Wirral Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for health and social care activities. The pool is hosted by Wirral Borough Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

21. Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Allen & Partners (Naomi Rankin is also a GP Partner at Belle Vale Medical Centre)	1,654	-	-	-
iGPC Primary Care Network (Naomi Rankin is also a Clinical Director and Shareholder of iGPC Primary Care Network)	2,490	-	-	-
The Health Foundation (Ruth Hussey is also Deputy Chair of the The Health Foundation)	-	(222)	-	-
Voluntary Sector North West (Warren Escadale is also Chief Executive of Voluntary Sector North West)	524	-	-	-
Accurx LTD is considered a related party by virtue of relationships with the Department of Health and Social Care and therefore with the Group	1,922	-	-	-
Alzheimers Society is considered a related party by virtue of relationships with the Department of Health and Social Care and therefore with the Group	250	-	84	-
Keys Group is considered a related party by virtue of relationships with the Department of Health and Social Care and therefore with the Group	58	-	20	-
NHS Confederation is considered a related party by virtue of relationships with the Department of Health and Social Care and therefore with the Group	40	-	-	-

Transactions with the parties above were on the same trading terms as other suppliers and providers.

The Department of Health and Social Care is a related party and the parent body. During the year the ICB has had a significant number of material transactions with entities which the Department is regarded as the parent.

The main parties in the public sector with which the ICB had dealings were:

NHS England
NHS Business Services Authority
Alder Hey Children's Hospital NHS Foundation Trust
Bridgewater Community Healthcare NHS Foundation Trust
Cheshire and Wirral Partnership NHS Foundation Trust
East Cheshire NHS Trust
Liverpool Heart and Chest Hospital NHS Foundation Trust
Liverpool University Hospital NHS Foundation Trust
Liverpool Women's NHS Foundation Trust
Manchester University NHS Foundation Trust
Mersey Care NHS Foundation Trust
Mersey and West Lancashire Teaching Hospitals NHS Trust
Mid Cheshire Hospitals NHS Foundation Trust
North West Ambulance Service NHS Trust
The Clatterbridge Cancer Centre NHS Foundation Trust
The Countess of Chester Hospital NHS Foundation Trust
The Walton Centre NHS Foundation Trust
Warrington and Halton Hospitals NHS Trust
Wirral Community NHS Foundation Trust
Wirral University Teaching Hospital NHS Foundation Trust
Cheshire East Council
Cheshire West and Chester Council
Halton Borough Council
Knowsley Council
Liverpool City Council
Metropolitan Borough Council of Sefton
St Helens Borough Council
Warrington Borough Council
Wirral Council

22. Events after the end of the reporting period

On 13 March 2025, the UK government signified their intention to reduce ICB management costs expenditure to a new cost per head of population of £18.76. This will have an impact on the operations of NHS Cheshire and Merseyside ICB in the forthcoming financial year, the extent to which is not yet fully known.

23. Losses and special payments

	2024-25 Total Number of Cases	**2024-25 Total Value of Cases £'000**	2023-24 Total Number of Cases	2023-24 Total Value of Cases £'000
Administrative write-offs	7	23	-	-
Cash losses	1	5	-	-
	8	**28**	-	-

24. Financial performance targets

NHS Integrated Care Board have a number of financial duties under the NHS Act 2006 (as amended).
NHS Integrated Care Board performance against those duties was as follows:

	2024-25 Target £'000	**2024-25 Performance £'000**	2023-24 Target £'000	2023-24 Performance £'000
Expenditure not to exceed income	8,049,506	8,024,101	6,799,820	6,796,601
Capital resource use does not exceed the amount specified in Directions	1,519	1,519	1,127	1,115
Revenue resource use does not exceed the amount specified in Directions	7,955,548	7,930,143	6,705,492	6,702,273
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	48,572	48,103	53,436	51,558

Appendix One – Board and Committee Membership and Attendance

NHS Cheshire and Merseyside Board

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Raj Jain (Chair)	Chair of NHS Cheshire and Merseyside	6 (6)
Graham Urwin	Chief Executive of NHS Cheshire and Merseyside	6 (6)
Tony Foy	Non-Executive Member of NHS Cheshire and Merseyside	6 (6)
Erica Morriss	Non-Executive Member of NHS Cheshire and Merseyside	5 (6)
Neil Large MBE (left February 2025)	Non-Executive Member of NHS Cheshire and Merseyside	5 (5)
Professor Hilary Garratt CBE	Non-Executive Member of NHS Cheshire and Merseyside	5 (6)
Dr Ruth Hussey CB, OBE, DL	Non-Executive Member of NHS Cheshire and Merseyside	6 (6)
Professor Steven Broomhead MBE	Partner Member (Local Authority) of NHS Cheshire and Merseyside	5 (6)
Councillor Paul Cummins (left May 2024)	Partner Member (Local Authority) of NHS Cheshire and Merseyside	0 (0)
Andrew Lewis (joined September 2024)	Partner Member (Local Authority) of NHS Cheshire and Merseyside	4 (4)
Ann Marr OBE	Partner Member (NHS Trust) of NHS Cheshire and Merseyside	5 (6)
Professor Joe Rafferty CBE (left October 2024)	Partner Member (NHS Trust) of NHS Cheshire and Merseyside	1 (3)
Trish Bennett (joined September 2024)	Partner Member (NHS Trust) of NHS Cheshire and Merseyside	4 (4)
Adam Irvine	Partner Member (Primary Care) of NHS Cheshire and Merseyside	6 (6)
Dr Naomi Rankin	Partner Member (Primary Care) of NHS Cheshire and Merseyside	5 (6)
Claire Wilson (left December 2024)	Executive Director of Finance of NHS Cheshire and Merseyside	4 (4)
Professor Rowan Pritchard-Jones	Medical Director of NHS Cheshire and Merseyside	5 (6)
Mark Bakewell (joined December 2024)	Interim Director of Finance of NHS Cheshire and Merseyside	2 (2)

Name	Position & Organisation	Attendance (eligible to attend)
Christine Douglas MBE	Director of Nursing and Care of NHS Cheshire and Merseyside	5 (6)
Mike Burrows (joined March 25)	Non-Executive Member of NHS Cheshire and Merseyside	1 (1)
Warren Escadale (joined October 2024)	Non-Executive Member of NHS Cheshire and Merseyside	3 (3)

The quorum for meetings of the Board will be a majority of members (8) including: The Chair and Chief Executive (or designated deputies), at least one Executive Director, at least one Non-Executive Director, at least one Partner Member and at least one member who has a clinical background or qualification.

Audit Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Neil Large MBE (Chair) (left February 2025)	Non-Executive Member of NHS Cheshire and Merseyside	6 (6)
Tony Foy	Non-Executive Member of NHS Cheshire and Merseyside	5 (7)
Erica Morriss	Non-Executive Member of NHS Cheshire and Merseyside	7 (7)
Professor Hilary Garratt CBE	Non-Executive Member of NHS Cheshire and Merseyside	3 (7)
Dr Ruth Hussey CB, OBE, DL	Non-Executive Member of NHS Cheshire and Merseyside	7 (7)

For a meeting to be quorate, a minimum of two Non-Executive members of the Board are required, including the Chair or Vice Chair of the Committee.

Remuneration Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Tony Foy (Chair)	Non-Executive Member of NHS Cheshire and Merseyside	6(6)
Erica Morriss	Non-Executive Member of NHS Cheshire and Merseyside	4(6)
Neil Large MBE (left February 2025)	Non-Executive Member of NHS Cheshire and Merseyside	5(6)
Professor Hilary Garratt CBE	Non-Executive Member of NHS Cheshire and Merseyside	1(6)
Dr Ruth Hussey CB, OBE, DL	Non-Executive Member of NHS Cheshire and Merseyside	5 (6)

For a meeting to be quorate, a minimum of two of the Non-Executive Members of the Board is required, including the Chair or the Vice Chair.

Finance, Investment and Our Resources Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Erica Morriss (Chair)	Non-Executive Member of NHS Cheshire and Merseyside	10(10)
Tony Foy	Non-Executive Member of NHS Cheshire and Merseyside	6(10)
Neil Large MBE (left February 2025)	Non-Executive Member of NHS Cheshire and Merseyside	8(8)
Claire Wilson (left December 2024)	Director of Finance of NHS Cheshire and Merseyside	7(7)
Clare Watson	Assistant Chief Executive of NHS Cheshire and Merseyside	10(10)
Christine Douglas MBE	Executive Director of Nursing and Care of NHS Cheshire and Merseyside	9(10)
Christine Samosa (left December 24)	Chief People Officer of NHS Cheshire and Merseyside	6(7)
Anthony Middleton	Director of Performance and Planning of NHS Cheshire and Merseyside	7(10)
Mark Bakewell (joined December 2024)	Interim Executive Director of Finance	4(4)
Attendance by Alex Mitchell, Alan Howgate and Mark Wilkinson	Associate Director of 'Place' Finance representative of NHS Cheshire and Merseyside	4(10)
Adam Irvine	Primary Care Partner Member of NHS Cheshire and Merseyside	8(10)
Jane Tomkinson	Partner CEO from at least one of each of the Cheshire and	8(10)

Name	Position & Organisation	Attendance (eligible to attend)
	Merseyside provider collaboratives	
Rob Collins	Integrated Care System Provider Finance Director	5(10)
Susannah Lynch	Chief Pharmacist of NHS Cheshire and Merseyside ICB	7(10)
Mike Gibney (Joined January 2025)	Chief People Officer of NHS Cheshire and Merseyside ICB	3 (3)

For a meeting to be quorate, at least 50% of the membership must be present (six). This should include two NHS Cheshire and Merseyside Executives, one Non-Executive member of the Board and one Partner Member.

Quality and Performance Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Tony Foy (Chair)	Non-Executive Member of NHS Cheshire and Merseyside	12(12)
Professor Hilary Garratt CBE	Non-Executive Member of NHS Cheshire and Merseyside	10(12)
Dr Naomi Rankin	Primary Care Partner Member of NHS Cheshire and Merseyside	12(12)
Christine Douglas MBE	Director of Nursing and Care of NHS Cheshire and Merseyside	12(12)
Professor Rowan Pritchard-Jones	Medical Director of NHS Cheshire and Merseyside	9(12)
Anthony Middleton	Director of Planning and Performance of NHS Cheshire and Merseyside	12(12)
Clare Watson	Assistant Chief Executive of NHS Cheshire and Merseyside	9(12)
Councillor Paul Cummins (left May 2024)	Partner Member (Local Authority) of NHS Cheshire and Merseyside	1(1)

For a meeting to be quorate, there must be one Non-Executive member of the Board present, including one other Non-Executive member of the Board or Partner Member and either the Medical Director or Director of Nursing and Care.

System Primary Care Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Erica Morriss (Chair)	Non-Executive Member of NHS Cheshire and Merseyside	6 (6)
Tony Foy	Non-Executive Member of NHS Cheshire and Merseyside	4 (6)
Adam Irvine	Primary Care Professional Group representative – Pharmacy / Primary Care Partner Member for of NHS Cheshire and Merseyside	5 (6)
Dr Daniel Harle	Primary Care Professional Group representative – Primary medical care	5 (6)
Clare Watson	Assistant Chief Executive of NHS Cheshire and Merseyside	5 (6)
Claire Wilson (left December 2024)	Director of Finance of NHS Cheshire and Merseyside	0 (3)
Mark Bakewell (joined December 2024)	Director of Finance (Interim) of NHS Cheshire and Merseyside	2 (2)
Chris Leese	Associate Director of Primary Care of NHS Cheshire and Merseyside	5 (6)
Christine Douglas MBE	Director of Nursing and Care of NHS Cheshire and Merseyside	4 (6)
Professor Rowan Pritchard-Jones	Medical Director of NHS Cheshire and Merseyside	4 (6)
Anthony Leo	Halton Place Director of NHS Cheshire and Merseyside	5 (6)
Tom Knight	Head of Primary Care of NHS Cheshire and Merseyside	6 (6)
Dr Jonathan Griffiths	Associate Medical Director of NHS Cheshire and Merseyside	5 (6)
Dr Naomi Rankin	Primary Care Partner Member of NHS Cheshire and Merseyside	5 (6)

For a meeting to be quorate, there must be at least five committee members present including, at least one Non-Executive member of the Board or Partner Member, at least one clinical member and at least two NHS Cheshire and Merseyside Directors

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Strategy and Transformation Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Ruth Hussey (Chair)	Non-Executive Member of NHS Cheshire and Merseyside	4 (4)
Clare Watson	Assistant Chief Executive of NHS Cheshire and Merseyside	4 (4)
Christine Douglas MBE	Director of Nursing and Care of NHS Cheshire and Merseyside	1 (4)
Dr Fiona Lemmens	Deputy Medical Director of NHS Cheshire and Merseyside	3 (4)
Carl Marsh	Warrington Place Director of NHS Cheshire and Merseyside	2 (4)
Mark Bakewell (left December 2024)	Liverpool Place Director of NHS Cheshire and Merseyside	1 (4)
Professor Ian Ashworth	Director of Population Health of NHS Cheshire and Merseyside	4 (4)
Tony Mayer	Managing Director, MHLDC provider Collaborative Representative	4 (4)
Linda Buckley	Managing Director, CMAST Provider Collaborative Representative	2 (4)

For a meeting to be quorate, there must be at least five committee members present including, at least one Non-Executive member of the Board or Partner Member, at least one clinical member and at least two NHS Cheshire and Merseyside Directors.

Children and Young People's Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Raj Jain (Chair)	Chair, NHS Cheshire and Merseyside	4 (5)
Denise Roberts	Associate Director of Quality and Safety Improvement, Halton Place, NHS Cheshire and Merseyside ICB	4 (5)
Louise Shepherd CBE	Chief Executive, Alder Hey Children's Hospital NHS FT	3 (5)
Christine Douglas MBE	Executive Director of Nursing & Care, NHS Cheshire and Merseyside	3 (5)
Simon Banks	Wirral Place Director, NHS Cheshire and Merseyside	4 (5)
Clare Watson	Assistant Chief Executive, NHS Cheshire and Merseyside	4 (5)
Dani Jones	Chief Strategy & Partnerships Office, Alder Hey Children's Hospital NHS FT	4 (5)
Dave Packwood	C&M VCSE Children and Young People Network Manager	4 (5)
Dr Elizabeth Crabtree	Programme Director, Alder Hey Children's Hospital NHS FT	4 (5)
Carly Brown	Change and Integration Director, Children's Services, Cheshire and Merseyside	2 (5)
Kelly Taylor	Head of Children & Young People Transformation Programme, NHS England – North West	2 (5)
Professor Ian Ashworth	Associate Director of Population Health, NHS Cheshire and Merseyside	4 (5)
Amanda Perraton	Director, Children's Social Care (DCS), Warrington Borough Council then Cheshire West and Chester Council	3 (5)
Bev Morgan	CEO, Koala North West	4 (5)
Sinead Clarke	Associate Medical Director for System Quality & Improvement, NHS Cheshire and Merseyside	5 (5)
Kath O'Dwyer	Chief Executive, St Helens Borough Council	3 (5)
Gill Bainbridge*	Chief Executive, Merseyside Youth Association	2 (2)
Dave McNicholl	Chief Executive, Onside Warrington Youth Zone	4 (5)
Stuart Dunne	Chief Executive Officer, Youth Focus NW	4 (5)
Jenny Turnross	Corporate Director of Children & Young People's Services, Liverpool City Council	1 (5)

Name	Position & Organisation	Attendance (eligible to attend)
Nasima Patel	Programme Director Change & Integration (DCS) Programme, hosted @ Wirral MBC	3 (3)

For a meeting or part of a meeting to be quorate a minimum of 50% of the membership must be present, including the Chair or Deputy Chair.

Women's Hospital Services in Liverpool Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Professor Hilary Garratt CBE (Chair)	Non-Executive Director of NHS Cheshire and Merseyside	4(4)
Dr Naomi Rankin	Primary Care Partner Member of NHS Cheshire and Merseyside	2(4)
Christine Douglas MBE	Executive Director of Nursing & Care of NHS Cheshire and Merseyside	4(4)
Dr Fiona Lemmens	Deputy Medical Director of NHS Cheshire and Merseyside	3(4)
Mark Bakewell (Left December 2024)	Liverpool Place Director of NHS Cheshire and Merseyside	2(3)
Anthony Leo (Joined February 2025)	Liverpool Place Director of NHS Cheshire and Merseyside	1(1)
Alison lee	Knowsley Place Director of NHS Cheshire and Merseyside	1(4)
Deborah Butcher	Sefton Place Director of NHS Cheshire and Merseyside	4(4)
James Sumner	Chief Executive, LUFHT & LWH	4(4)
Mandish Dhanjal	Independent Clinical Senior Responsible Officer	3(4)
Dr Lynn Greenhalgh (Left November 2024)	Chief Medical Officer	3(3)
Chris Dewhurst (Joined November 24)	Chief Medical Officer, Liverpool Women's NHS FT (LWH)	0(1)
Sheena Khanduri	Medical director – Clatterbridge Cancer Centre	0(4)
Catherine McClennan	Director, Cheshire & Merseyside Local Maternity and Neonatal System	4(4)
Nigel Scawn	Medical Director Countess of Chester.	3(4)
Andrew Bibby	Regional Director of Health & Justice and Specialised Commissioning, NHS England representative	3(4)

Name	Position & Organisation	Attendance (eligible to attend)
Rob Nolan	Associate Director of Finance - Liverpool Place of NHS Cheshire and Merseyside	3(4)
John Grinnell (Joined November 2024)	CEO/CFO – Alder Hey	1(1)
Louise Shepherd (Left November 2024)	CEO Alder Hey	1(3)

For a meeting or part of a meeting to be quorate a minimum of five Committee members need to be present, including, the Committee Chair or Deputy Chair, at least one NHS Trust representative, at least one clinically qualified member, at least one ICB Executive member.

North West Specialised Services Joint Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Clare Watson	Assistant Chief Executive, NHS Cheshire and Merseyside	5 (5)
Rob Bellingham	Director of Primary Care and Strategic Commissioning, NHS Greater Manchester	2 (5)
Professor Craig Harris	Chief of Health and Care Integration, NHS Lancashire and Cumbria	4 (5)
Dr Ruth Hussey (Chair)	Non-Executive Member of NHS Cheshire and Merseyside	4 (4)
Jim Birrell	Non-Executive Member of NHS Lancashire and Cumbria	4 (5)
Dame Sue Bailey	Non-Executive Member of NHS Greater Manchester	2 (5)

For a meeting to be quorate, there must be the authorised officer (or substitute) nominated by NHS England, and each of the authorised officer (or substitutes) appointed by each of the three ICBs.

Cheshire and Merseyside Health Care Partnership

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Councillor Louise Gittins (Chair)	Political Representative, Cheshire West and Chester Council	5 (5)
Rev Ellen Loudon (Vice Chair)	Director of Social Justice & Canon Chancellor, Diocese of Liverpool	4 (5)
Raj Jain (Vice Chair)	Chair of NHS Cheshire and Merseyside	4 (5)
Graham Urwin	Chief Executive of NHS Cheshire and Merseyside	2 (5)

Name	Position & Organisation	Attendance (eligible to attend)
Clare Watson	Assistant Chief Executive NHS Cheshire and Merseyside	5 (5)
Mark Bakewell	Interim Director of Finance of NHS Cheshire and Merseyside/Liverpool Place Director	3 (5)
Councillor Christine Bannon	Political representative, Knowsley Metropolitan Borough Council	4 (5)
Councillor Marlene Quinn	Political representative, St Helens Borough Council	1 (5)
Councillor Susan Murphy	Political representative St Helens Borough Council	1 (5)
Councillor Andy Bowden	Political representative St Helens Borough Council	2 (5)
Councillor Paul Warburton	Political representative, Warrington Borough Council	1 (5)
Councillor Ian Moncur	Political representative, Sefton Council	3 (5)
Councillor Jane Corbett	Political representative, Liverpool City Council	2 (5)
Councillor Richard McClean	Political representative Liverpool City Council	1 (5)
Councillor Angela Coleman	Political representative Liverpool City Council	2 (5)
Councillor Sam Corcoran	Political representative, Cheshire East Council	3 (5)
Councillor Marie Wright	Political representative, Halton Borough Council	4 (5)
Cllr Jean Robinson	Political Representative, Wirral Council	2 (5)
Cllr Maureen McLoughlin	Chair of Health and Wellbeing Board-Warrington Borough Council	4 (5)
Professor Ian Ashworth	Director of Population Health	5 (5)
Margaret Jones	Director of Public Health	3 (5)
Gareth Lee	Detective Chief Superintendent, Cheshire Police	0 (5)
Lee Shears	Deputy Chief Fire Officer, Cheshire Fire and Rescue	3 (4)
Phil Garrigan	Chief Fire Officer, Merseyside Fire and Rescue	2 (5)
Dave Mottram	Merseyside Fire and Rescue	1 (5)
Matt Smith	Merseyside Police	3 (5)
Georgina Garvey	Merseyside Police	3 (5)
Jennifer Wilson	Merseyside Police	1 (5)

Name	Position & Organisation	Attendance (eligible to attend)
Alison Cullen	Chief Executive Officer, Warrington Voluntary Action, Voluntary, Community and Faith Sector Representative (Cheshire)	1 (5)
Racheal Jones	Chief Executive Officer, One Knowsley, Voluntary, Community and Faith Sector Representative (Merseyside)	5 (5)
Adam Irvine	Primary Care Partner Member of NHS Cheshire and Merseyside Representative	4 (5)
Dame Jo Williams	Chair of Alder Hey Children's Hospital Trust - Provider Collaborative (CMAST)	3 (5)
Steve McQuirk	Chair of WHH and deputy for Dame Jo Williams	1 (5)
Isla Wilson	Chair of Cheshire & Wirral Partnership NHS FT - Provider Collaborative Representative (MHLDSC)	4 (5)
Kate Shone	Managing Director, Torus Foundation	2 (5)
Cath Murray-Howard	Deputy Chief Executive, Torus Housing Association	1 (5)
Diane Blair	Chief Executive, Sefton Healthwatch	1 (5)
Sarah Thwaites	Chief Executive, Healthwatch Liverpool	1 (5)
Jayne Parkinson-Loftus	Chief Executive, Healthwatch St Helens	2 (5)
Louise Barry	Chief Executive, Healthwatch Cheshire	1 (5)
Karen Prior	Chief Executive, Healthwatch Wirral	1 (5)
Gideon Ben Tovim	Health Innovation Chair of LCR Climate Partnership	3 (5)
Alison Lee	Knowsley Place Director of NHS Cheshire and Merseyside	1 (5)
Carl Marsh	Warrington Place Director of NHS Cheshire and Merseyside	1 (5)
Mark Wilkinson	Cheshire Place Director of NHS Cheshire and Merseyside	1 (5)
Mark Palethorpe	St Helens Place Director of NHS Cheshire and Merseyside	1 (5)
Nicola Freaney	Partnership Manager, Department of Work and Pensions	3 (5)

Name	Position & Organisation	Attendance (eligible to attend)
Steve Park	Director of Growth, Warrington Borough Council	3 (5)
Nikki O'Connor	C&M (and Greater Manchester) DWP Strategic Partnership Manager	2 (5)
Maud Larkin	North West Ambulance Service	2 (5)
Carly Brown	Children's Services, Liverpool City Council	1 (5)

For the Health and Care Partnership to be quorate, there must be 50% of the membership present